Sandia National Laboratories

CIGNA Healthcare In-Network Plan

Summary Plan Description

Effective: January 1, 2006

CIGNA Healthcare In-Network Plan

Introduction

This Summary Plan Description (***SPD***) summarizes the CIGNA In-Network Plan operations, benefits, claim filing procedures, and other Plan provisions. As you read through this ***SPD***, you'll learn more about the covered services and special programs and tools that this Plan offers to help you take better care of yourself.

The CIGNA In-Network Plan is being offered by Sandia National Laboratories to its employees, non-***Medicare*** primary retirees, and other eligible non-***Medicare*** primary individuals. When you need medical care, this Plan allows you to see any Open Access Plus Network ***provider*** or facility.

In addition to medical services, this In-Network Plan includes an Employee Assistance Program, a Behavioral Health Program, a Disease Management Program, and a Prescription Drug Program.

As alternatives to this Plan, Sandia offers

- to its employees and eligible dependents the UnitedHealthcare Premier PPO, UnitedHealthcare Standard PPO, CIGNA Premier PPO, and Kaiser HMO (CA)
- to its non-***Medicare*** retirees and other non-Medicare primary eligible individuals the UnitedHealthcare Premier PPO, UnitedHealthcare High-Deductible Health Plan, CIGNA Premier PPO, and Kaiser HMO (CA)
- to its ***Medicare*** primary retirees and other ***Medicare*** primary individuals the UnitedHeathcare Senior Premier PPO, CIGNA Senior Premier PPO, Presbyterian MediCare PPO (NM), Lovelace Senior Plan (NM), and Kaiser Senior Advantage Plan (CA).

These alternatives are described by their individual SPD.

As a ***member*** in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income and Security Act (ERISA) of 1974. This information, as well as certain general information concerning the Plan, is included as a separate booklet called *ERISA Information*.

The CIGNA In-Network Plan is a self-insured plan for eligible ***members*** of Sandia Corporation, 1515 Eubank SE, Albuquerque, NM 87123 (employer identification number 85-0097942, plan number 519). This Plan is administered on a calendar year basis from

January 1 through December 31 for accumulation of maximums, ***deductibles***, claim filing, and filing of reports to the Department of Labor. CIGNA HealthCare, the Claims Administrator, has assigned the following group plan number 3172368. For information concerning service of legal process, contact the Sandia Legal Division, Sandia National Laboratories, 1515 Eubank SE, MS0141, Albuquerque, NM 87123.

The information contained in this ***SPD*** is provided in accordance with the requirements of the ERISA of 1974 and the Internal Revenue Code (***IRC***).

Copies of this ***SPD*** and the administrative manual are available (for a fee) from your Sandia Corporation (Sandia) Benefits office.

The CIGNA In-Network Plan is maintained at the discretion of Sandia and is not intended to create a contract of employment and does not change the at-will employment relationship between you and Sandia. The Sandia Board of Directors (or designated representative) reserves the right to change or amend any or all provisions of the CIGNA In-Network Plan, and to terminate the CIGNA In-Network Plan at any time without prior notice, subject to applicable collective bargaining agreements. If the CIGNA In-Network Plan should be terminated or changed, it will not affect your right to any benefits to which you have already become entitled.

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Section 1. Summary of Plan Changes from CIGNA Point of Service (POS) Plan

This section highlights the changes from the CIGNA POS Plan to the CIGNA In-Network Plan that is being offered by Sandia Laboratories to its employees, non-***Medicare*** retirees, and other eligible non-***Medicare*** individuals (including non-***Medicare*** Class I eligible dependents).

The CIGNA In-Network Plan is an HMO look-alike, in that it offers coverage for services from in-network ***providers*** **only**. The exception to this would be services for ***emergency*** and ***urgent*** medical care.

Class II dependents are not eligible for this Plan.

Note: ***Medicare***-primary individuals and Class II dependents may be eligible to enroll in the CIGNA Senior Premier PPO Plan or the CIGNA Premier PPO Plan (including individuals with end-stage renal disease who are eligible for ***Medicare***-primary coverage).

Highlights

- This Plan gives ***members*** referral-free access to CIGNA's nationwide network of ***providers***, which means that a referral is no longer required from your primary care physician to get services from any network ***specialist***.
- You are no longer required to select a primary care physician to coordinate your care.
- The primary care physician visit ***copay*** increased from $10 to $15 per visit.
- The ***specialist*** office visit ***copay*** increased from $10 to $25 per visit.
- The short-term rehabilitation therapies (acupuncture, chiropractic, occupational, physical, and speech) ***copay*** for ***outpatient*** care increased from $10 to $15 per visit.
- The ***urgent care copay*** is now $40 per visit.
- The ***emergency*** room ***copay*** increased from $50 to $100 per visit.
- The ***outpatient surgery copay*** increased from $75 to $100 per visit.
- The ***hospital inpatient*** admission ***copay*** changed from $250 per admission to $200 per day up to a maximum of $500 per admission.
- The ambulance service ***copay*** for emergencies is $50 per trip

- Certain preventive care is now covered at 100 percent instead of a $10 ***copay*** for routine physicals, well-baby care, and immunizations.
- ***Emergency*** and ***urgent care*** coverage is available worldwide at the in-network level of benefit. Any ***follow-up care*** must be from an in-network ***provider***.
- Infertility treatment is not covered under this Plan.
- ***Behavioral health*** coverage changed as follows:
  - ***Inpatient*** mental health coverage decreased from a maximum of 60 ***inpatient*** days to a maximum of 45 ***inpatient*** days.
  - ***Outpatient*** mental health coverage has a maximum of 30 visits per calendar year.
- ***Copays*** apply to your annual ***out-of-pocket maximum***, except for prescription drugs. The ***out-of-pocket maximum*** is your total financial responsibility for covered medical expenses before the Plan reimburses additional ***covered charges*** at 100 percent for the remaining portion of the calendar year.
- The Prescription Drug Program is administered through CIGNA HealthCare.
- The Prescription Drug Program is a two-tiered, closed ***formulary*** plan that includes generic and preferred-brand drugs. Nonpreferred brand-name drugs are not covered under this Plan.
- Prescription drugs may be obtained through either retail or mail-order pharmacies.
- Prescription drugs purchased through a retail pharmacy are for up to a 30-day supply. The retail prescription drug ***copay*** for brand-name drugs increased from $20 to $30 for up to a 30-day supply.
- Prescription drugs purchased through mail order are for up to a 90-day supply. The Mail-Order Drug Program is through Tel-Drug. Ask your doctor for a mail-order prescription for maintenance drugs. The mail order prescription drug ***copay*** increased from $40 to $60 for up to a 90-day supply.
- Primary ***covered members*** can enroll a new dependent based on a birth or marriage within 31 calendar days, but if a copy of the birth certificate or marriage license is not provided within 60 calendar days of the birth or marriage, the dependent will be disenrolled from the Plan.
- Beginning January 1 of every year, you will need to update information on any other insurance your covered dependents have, even if your dependents do not have other insurance.
- Primary ***covered members*** who have dependents covered under the Plan who are not tax dependents under IRC Section 152 for purposes of health care coverage will have imputed income.
- Coverage tiers for premium sharing changed from:

Before	Current
employee only	employee only
employee plus one dependent	employee and spouse
employee plus two or more dependents	employee and child(ren)
	employee and spouse and child(ren)

Guidelines

You or a family member must call CIGNA within 48 hours (or as soon as reasonably possible) whenever hospitalized for any out-of-network ***emergency*** care. Call CIGNA Member Services at 1-800-244-6224 for details.

Member Resources

CIGNA HealthCare offers the following ***member*** resources to aid ***members*** in managing their care and achieving better health.

- ***Members*** may obtain a list of network ***providers***, order ID cards, view claim history, and view explanation of benefits (EOBs) by registering at mycigna.com
- ***Behavioral health providers'*** lists, including ***EAP***, can be obtained at cignabehavioral.com
- The Disease Management Program is a voluntary program that helps ***members*** manage chronic conditions for asthma, diabetes, heart disease, low back pain, and chronic obstructive pulmonary disease. ***Members*** receive personalized guidance and support from an experienced registered nurse as well as reminders about important screenings and exams.
- The CIGNA HealthCare 24-Hour Health Information Line^{SM} is available 24 hours a day, seven days a week, at 1-800-564-9286.

Section 2. Eligibility

This section outlines who is eligible to enroll in this Plan. As described below, the following groups are eligible to enroll in this Plan:

- Active employees who are not eligible for ***Medicare*** primary coverage
- Employees who are on a ***leave of absence*** and are not eligible for ***Medicare*** primary coverage
- Retirees who are not eligible for ***Medicare*** primary coverage
- ***Long-term disability terminees*** who are not eligible for ***Medicare*** primary coverage
- Surviving spouses who are not eligible for ***Medicare*** primary coverage
- ***Covered members*** who elect temporary coverage under ***COBRA***

This section also provides information concerning who may qualify for dependent coverage under this Plan. The end of this section provides information on Qualified Medical Child Support Orders (***QMCSO***) and your appeal rights concerning eligibility status determinations.

Note: Under this Plan, ***covered members*** cannot be covered as both a primary ***covered member*** and as a dependent, or a dependent of more than one primary ***covered member***.

Covered members who become eligible for ***Medicare*** primary coverage should enroll in ***Medicare*** Parts A and B. Once a ***covered member*** becomes eligible for ***Medicare*** primary coverage, Sandia will pay benefits only as a secondary payer for benefits provisions under this Plan, regardless of whether the ***member*** enrolled in ***Medicare*** Parts A and B.

Important

*If a **covered member** who is eligible for **Medicare** primary coverage is provided primary coverage under this or any other Sandia-sponsored medical plan, the primary **covered member** will be responsible for reimbursing Sandia for any ineligible benefits.*

Refer to the booklet *Medicare & You* for more information. You can access the booklet from ***Medicare*** at medicare.gov or 1-800-633-4227, or from your local Social Security office.

Employees

You, as a Sandia employee, are eligible to enroll in this Plan. If you enroll within 31 calendar days of your hire date, your medical coverage is effective as of your hire date. The following types of Sandia employees are eligible for coverage:

- Regular, full- or part-time employees as classified by Sandia for payroll purposes
- Limited-term exempt or non-exempt employees
- Faculty sabbatical appointees not eligible for other group health care coverage
- Year-round student interns who are enrolled in a post-secondary educational program and who are not covered by another medical plan

For purposes of coverage under this Plan, you, as an employee, are eligible only if:

- You satisfied all requirements for coverage under the Plan
- Sandia withholds required federal, state, or FICA taxes from your payroll paycheck
- Sandia issues you a W-2 for the year in which a medical service under this Plan is provided
- Sandia issues to you the W-2 above no later than the year following the year in which the medical service was provided.

EXCEPTIONS

An employee receiving benefits under Sandia's Job Incurred Accident Disability Plan who does not have taxes withheld by Sandia from his/her paycheck, but who otherwise satisfies the eligibility requirements of this Plan, is an employee for purposes of coverage under this Plan.

An employee on inactive status because he or she is on a Sandia-approved ***leave of absence***, as evidenced by the written approval required for such leave, who otherwise satisfies the eligibility requirement of this Plan, is an employee for purposes of coverage under this Plan.

Retirees

Covered members who retire and are enrolled in this Plan and are not eligible for ***Medicare*** primary (under age 65) coverage may continue primary coverage under this Plan. Retirement from Sandia is a ***qualifying event*** allowing you to change your medical plan coverage. You may change your medical plan coverage if you do so within 31 calendar days of your retirement date.

If you elect to remain enrolled in this Plan, this Plan will continue to be your primary coverage until such time that you become eligible for ***Medicare*** primary coverage.

Upon becoming eligible for ***Medicare*** primary coverage (turning age 65), you have the option of enrolling in either the CIGNA Senior Premier PPO Plan or the Lovelace Senior Plan (certain NM counties only). You also have the option of dropping coverage. You must notify Sandia Benefits, in writing, within 31 calendar days of becoming eligible for ***Medicare*** primary coverage of any change you decide to make.

If you do not notify Sandia Benefits within 31 calendar days of becoming eligible for ***Medicare*** primary coverage, your coverage will be defaulted to the CIGNA Senior Premier Plan. Your next opportunity to select a different plan will be during the ***open enrollment*** period Sandia holds each fall, and coverage will be effective January 1 of the following calendar year.

All ***Medicare*** primary family members must be enrolled in the same plan; and all non-***Medicare***-primary family members must be enrolled in the same plan.

Note: ***Covered members*** who will become age 65 will be sent a courtesy letter by Sandia Benefits informing them of the opportunity to enroll in ***Medicare*** and of the medical plan options available to them. However, not receiving this letter does not relieve the ***covered member's*** responsibility for enrolling in ***Medicare*** Parts A and B to receive full benefits.

You can enroll in the Lovelace Senior Plan only if you are enrolled in both ***Medicare*** Parts A and B.

Long-Term Disability Terminees

Covered members who are approved for and receiving long-term disability benefits under the Sandia Long-Term Disability Plan or the Sandia Long-Term Disability Plus Plan may continue their primary coverage under this Plan.

This Plan will continue to be your primary coverage until such time that you become eligible for ***Medicare*** primary coverage. If you have been receiving Social Security disability benefits for 24 months or longer, you are eligible for ***Medicare*** primary coverage.

Upon becoming eligible for ***Medicare*** primary coverage, you have the option of enrolling in either the CIGNA Senior Premier PPO Plan or the Lovelace Senior Plan (certain NM counties only). You also have the option of dropping coverage. You must notify Sandia Benefits, in writing, within 31 calendar days of becoming eligible for ***Medicare*** primary coverage of any change you decide to make.

If you do not notify Sandia Benefits within 31 calendar days of becoming eligible for ***Medicare*** primary coverage, your coverage will be defaulted to the CIGNA Senior Premier Plan. Your next opportunity to select a different plan will be during the ***open en-***

rollment period Sandia holds each fall, and coverage will be effective January 1 of the following calendar year.

All ***Medicare*** primary family members must be enrolled in the same plan, and all non-***Medicare*** primary family members must be enrolled in the same plan.

Long-Term Disability Plan terminees include ***covered members*** (who are not eligible for ***Medicare*** primary coverage) who after January 1, 1982, became disabled before retirement and have been approved for and have been receiving Sandia's long-term disability benefits.

Important

*Terminating from Sandia is a **qualifying event** that allows you to change your medical plan when you notify Sandia Benefits, in writing, within 31 calendar days of your retirement date.*

All ***Medicare*** primary family members must be enrolled in the same plan, and all non-***Medicare*** primary family members must be enrolled in the same plan.

Other Eligible Persons

You are also eligible to enroll in this Plan if you are a(n):

- Employee on certain leaves of absence (an employee on inactive status because he/she is on a Sandia-approved ***leave of absence***, as evidenced by the written approval required for such leave) who otherwise satisfied the eligibility requirements of this Plan, is a covered employee for purposes of coverage under this Plan)
- Surviving spouse (who is not eligible for ***Medicare*** primary coverage) of a regular Sandia employee or retiree
- ***Covered member*** who elects and pays for temporary coverage (***COBRA***) and pays the appropriate premium when required (see Section 13, Continuation of Group Health Coverage)

Eligible Dependents

- Class I dependents are eligible for enrollment in the same Sandia-sponsored medical plan as the primary ***covered member***.
- Eligible plan dependents are those individuals who are dependents of a primary ***covered member*** and any ***child*** of a primary ***covered member*** who is recognized as an ***alternate recipient*** in a Qualified Medical Child Support Order (***QMCSO***).
- Your covered dependents who become eligible for ***Medicare*** primary coverage should enroll in ***Medicare*** Parts A and B. Once your covered dependents become eligible for ***Medicare*** primary coverage, Sandia will pay benefits only as a secon-

dary payer for benefits provisions under the Plan, regardless of whether your covered dependents enroll in ***Medicare*** Parts A and B.

Important

*If your covered dependent who is eligible for **Medicare** primary coverage is provided primary coverage under this or any other Sandia-sponsored medical plan, the primary **covered member** will be responsible for reimbursing Sandia for any ineligible benefits.*

Refer to the booklet *Medicare & You* for more information. You can access the booklet from ***Medicare*** at medicare.gov or 1-800-633-4227, or from your local Social Security office.

Important

*As an employer, Sandia is obligated to accurately withhold income and employment taxes. If your plan dependent does not qualify as a dependent under **IRC** Section 152 for purposes of medical coverage for the entire year, you may be subject to imputed income. Refer to Section 4, Group Health Plan Premiums, for more information.*

Class I Dependents

If you are the primary ***covered member*** under this Plan, your non-***Medicare*** primary Class I dependents who are eligible for coverage under this Plan include your:

- Spouse, not legally separated or divorced from you

  Note: An annulment also makes the spouse ineligible for coverage.

- Unmarried ***child*** under age 19, including legally adopted ***children***
- Unmarried ***child*** age 19 and over, but under age 24, who is ***financially dependent*** on you
- Unmarried ***child*** of any age who:
  - Is permanently and totally disabled and unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months
  - Lives with you, in an institution, or in a home that you provide
  - Is ***financially dependent*** on you
- Unmarried ***child*** who is recognized as an ***alternate recipient*** in a ***QMCSO***.

In addition, if you are a non-represented or OPEIU- or SPA-represented employee and are the primary ***covered member*** under this Plan, your Class I dependents eligible for coverage also include your:

- ***Domestic partner*** who meets all of the following requirements:
    - Is the same gender as the primary ***member***
    - Shares significant financial resources and dependencies
    - Has resided with the primary ***covered member*** continuously for at least six months in a sole-partner relationship that is intended to be permanent
    - Is unmarried
    - Is not related to the primary ***covered member*** by blood (e.g., brothers, sisters, parents, ***children***, cousins, nieces, uncles)
    - Is at least 18 years of age

    Note: Domestic partners who attain age 65 are considered as having Medicare as their primary coverage even if enrolled as a dependent of an employee.
- Your eligible ***domestic partner's*** unmarried ***child*** under age 19, including legally adopted ***children***
- Your eligible ***domestic partner's*** unmarried ***child*** age 19 and over, but under age 24, who is ***financially dependent*** on you
- Your eligible ***domestic partner's*** unmarried ***child*** of of any age who, because of a physical or mental impairment,
    - Is permanently and totally disabled and unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months
    - Lives with the primary ***covered member***, in an institution, or in a home that is provided by the primary ***covered member***
    - Is ***financially dependent*** on the primary ***covered member***
- Your eligible ***domestic partner's*** unmarried ***child*** who is recognized as an ***alternate recipient*** in a ***QMCSO***

Class II Dependents

Class II dependents are **not eligible** for coverage under the CIGNA In-Network Plan. If you are considering providing medical coverage for any Class II dependents, consider another Sandia-sponsored medical plan such as the CIGNA Premier PPO. **For information only,** Class II dependents include:

- Unmarried ***child*** or step-child who is not eligible as a Class I dependent
- Unmarried grandchild
- Unmarried brother or sister
- Your or your spouse's parent, step-parent, or grandparent

Provision for Covered Members with End-Stage Renal Disease

Covered members may be eligible for ***Medicare*** primary coverage due to end-stage renal disease.

This CIGNA In-Network Plan may continue as your primary coverage for the first 33 months (from the time you start dialysis), which includes the 30-month coordination period with ***Medicare*** as your secondary coverage. After the 30-month coordination period, ***Medicare*** will become your primary coverage.

Covered members who become eligible for ***Medicare*** primary coverage should enroll in ***Medicare*** Parts A and B. Once a ***covered member*** becomes eligible for ***Medicare*** primary coverage, Sandia will pay benefits only as a secondary payer for benefits provisions under the Plan, regardless of whether the ***member*** enrolls in ***Medicare*** Parts A and B.

Important

*If a **covered member** who is eligible for **Medicare** primary coverage is provided primary coverage under this or any other Sandia-sponsored medical plan, the primary **covered member** will be responsible for reimbursing Sandia for any ineligible benefits.*

Refer to the booklet *Medicare & You* for more information. You can access the booklet from ***Medicare*** at medicare.gov or 1-800-633-4227, or from your local Social Security office.

Qualified Medical Child Support Order

Generally, your Plan benefits may not be assigned or alienated. However, an exception applies in the case of any ***child*** of a primary ***covered member*** (as defined by ***ERISA***) who is recognized as an ***alternate recipient*** in a ***QMCSO***. A ***QMCSO*** is an order issued by a court or administrative agency pursuant to applicable state domestic relation laws that assigns a ***child*** the right of a participant or beneficiary to receive benefits under an employer-provided health plan, regardless of with whom the ***child*** resides. This Plan will comply with the terms of a ***QMCSO***.

An ***alternate recipient*** is any ***child*** of a primary ***covered member*** (including a ***child*** adopted by or placed for adoption with a primary ***covered member***) who is recognized

under a medical child support order as having a right to enrollment under a group health plan with respect to such primary ***covered member***.

Federal law provides that a medical child support order must meet certain form and content requirements in order to be a ***QMCSO***. When a medical child support order is received, each affected primary ***covered member*** and each ***child*** (or the child's representative) covered by the order will be given notice of the receipt of the order. Coverage under the Plan pursuant to a medical child support order will not become effective until the Plan administrator determines that the order is a ***QMCSO***. ***QMCSO***s will be reviewed by Sandia's Legal Organization within 40 business days. If you have any questions or you wish to obtain a copy of the procedures governing ***QMCSO*** determination, contact Sandia Health, Benefits, and Employee Services (HBES) at (505) 844-4237. You have a right to obtain, at no charge, a copy of the procedures governing ***QMCSO.***

Eligibility Appeal Procedures

If this Plan denies your claim or your dependent's claim because of eligibility, you may contact Sandia HBES at (505) 844-4237 to request a review of eligibility status. A written notification will be sent to you within three business days of your request, informing you of your eligibility status.

You may appeal any eligibility status determination by writing to the Sandia Employee Benefits Committee (EBC), Attention: Benefits Department, PO Box 5800, MS 1022, Albuquerque, NM 87185.

You must appeal to the EBC within 180 days of the date of the letter informing you of the eligibility status determination.

The EBC has the exclusive right to interpret eligibility. The secretary of the EBC has the authority to make the final determination for ***urgent care*** appeals. The determination of the EBC or its secretary is conclusive and binding.

You must exhaust the appeal process before you seek any other legal recourse.

Plan dependent eligibility based on incapacitation is determined by CIGNA HealthCare. Contact Sandia HBES at (505) 844-4237 for information on how to apply for dependent incapacitation status.

> **Note:** If you do not enroll a dependent because the dependent has other medical coverage and your dependent involuntarily loses eligibility for that coverage, you may be able to enroll the dependent in your medical plan provided that you request enrollment within 31 calendar days after the other coverage ends.

Section 3. Enrollment and Disenrollment

This section describes the enrollment procedures for new hire employees, how to enroll and disenroll dependents, and the consequence of not disenrolling dependents in a timely manner. It also provides information on your rights under the Health Insurance Portability and Accountability Act (***HIPAA***), the option to waive or drop coverage and the option of disenrolling and reenrolling if you take a ***leave of absence***, including a leave under the Family and Medical Leave Act (FMLA). For the events that may allow you to make ***mid-year election changes***, see the Pre-Tax Premium Plan booklet.

To enroll in this CIGNA In-Network Plan:

- Complete the medical enrollment form (SF 4400-MED). Keep a copy as proof of coverage until you receive your ID card(s) from CIGNA HealthCare.
- Complete the payroll deduction premium authorization form (SF 4811-HCC), making sure you indicate whether you want your premium to be deducted on a pre-tax or after-tax basis.

  Note: Refer to Section 4, Group Health Plan Premiums or consult your tax advisor for more information on whether your dependent qualifies for pre-tax health benefits.

- Mail those two forms to Sandia HBES at Mail Stop 1022 in adequate time to be received within the 31-calendar-day requirement for enrollment.

If you enroll in this medical Plan within 31 calendar days of your hire date, coverage will be retroactive to your date of hire. Your next opportunity to enroll in this Plan is during the ***open enrollment*** period Sandia holds each fall; coverage is effective January 1 of the following calendar year.

If you terminate employment and are rehired within 30 calendar days of this termination, you (and any covered dependents at the time of termination) will automatically be reinstated in this Plan. If you are rehired after 30-calendar days of termination, you are eligible to enroll in any Sandia-sponsored medical plan provided to employees.

New Hire Employees

If you are a newly hired Sandia employee who meets the eligibility criteria as outlined in Section 2, Eligibility, you are eligible to enroll for medical coverage under this Plan. You may also elect to enroll your eligible Class I dependents as outlined in Section 2.

Sandia HBES will provide you with a medical enrollment form (SF 4400-MED) and payroll deduction premium authorization form (SF 4811-HCC) for you to complete your enrollment in this Plan.

Note: You must enroll yourself and your eligible Class I dependents in this plan within 31 calendar days of your effective hire date in order to be covered from your first day of hire.

Enrolling Dependents

Enrolling Class I Dependents

All Class I dependents whom you elect to have covered under this Plan must be enrolled within 31 calendar days of the event qualifying them for coverage, such as when they are newly eligible (e.g., birth, adoption, marriage, becoming an employee).

If you want to add a ***domestic partner*** or a dependent of your ***domestic partner*** to your coverage under your medical plan, refer to the Domestic Partner packet. You can obtain this packet from the Sandia Benefits website or from Sandia HBES at (505) 844-4237.

The next opportunity for you to enroll your eligible Class I dependents will be during the ***open enrollment*** period Sandia holds each fall, and coverage will be effective January 1 of the following calendar year.

Effective date of coverage for your Class I dependents, enrolled within 31 calendar days of their ***qualifying event***, is as follows:

Dependent Due to	Effective Date of Coverage
Marriage	Later of the date of the event creating eligibility or the date Benefits receives completed paperwork
Legal Guardianship	Later of the date of the event creating eligibility or the date Benefits receives completed paperwork
Birth	Retroactive coverage to date of event (birth)
Adoption	Retroactive coverage to date of event (adoption) ***Note****: Medical expenses of the child before adoption, including the birth mother's prenatal, postnatal, and delivery charges, are not covered.*
Placement for Adoption	Retroactive coverage to date of event (placement) ***Note****: Medical expenses of the child before placement, including the birth mother's prenatal, postnatal, and delivery charges, are not covered.*

Important

*Documentation to verify dependent eligibility is required within 60 calendar days of the **qualifying event** for eligibility to enroll a dependent. The documentation required is as follows:*

- *Marriage license for spouse*
- *Birth certificate for birth*
- *Placement agreement or adoption papers for adopted child*

If you do not provide your marriage license or the birth certificate for your new dependent, your dependent will be disenrolled and will have coverage for only the first 60 calendar days beginning with the effective date of coverage.

Submit your documentation to Sandia Benefits at MS 1022.

All dependent information requested on the medical enrollment form (SF 4400-MED) must be provided, including:

- Dependent's complete name and relationship to you
- Social Security number (not applicable to newborns)
- Date of birth and gender

Note: Contact Sandia HBES at (505) 844-4237 for assistance.

Other Insurance Request for Dependents

Beginning January 1 of every year, or if you are a new enrollee, CIGNA HealthCare requires an update on whether any of your covered dependents have other insurance. This information must be provided even if your dependents do not have other insurance. If you do not provide this information, CIGNA HealthCare will put a hold on your dependent's claims and request other insurance verification, in writing, from the primary ***covered member***. You may update your other insurance information through mycigna.com or by calling CIGNA Member Services at 1-800-244-6224.

Enrolling Class II Dependents

Class II dependents are not eligible for coverage under the CIGNA In-Network Plan. You should consider another Sandia-sponsored medical plan such as the CIGNA Premier PPO if you are planning to enroll any Class II dependents.

Disenrolling Dependents

If your dependents do not meet the dependent eligibility criteria as required by this Plan, they do not qualify for coverage under this Plan, and you must disenroll them.

Note: Contact Sandia HBES at (505) 844-4237 for assistance.

All ineligible dependents must be disenrolled within 31 calendar days of the event that has made them no longer eligible for this Plan. Plan coverage ends at the end of the month in which the dependents became ineligible.

Events Causing Your Dependent to Become Ineligible

Your Class I dependents become ineligible for coverage under this Plan and must be disenrolled from this Plan when one or more of the following events occur:

- Legal separation, annulment, or divorce
- Dissolution of ***domestic partnership***
- ***Child***, ***domestic partner's*** child, marries
- ***Child***, ***domestic partner's*** child, is no longer ***financially dependent***
- ***Child***, ***domestic partner's*** child, no longer meets the age criteria
- Incapacitated ***child***, ***domestic partner's*** incapacitated child, no longer meets incapacitation criteria
- Dependent no longer meets the Class I criteria
- ***Child*** is no longer covered under the ***QMCSO***

If your premium deductions are on an after-tax basis, you can disenroll your dependent at any time without a ***qualifying event***; however, you can reenroll them only with a ***qualifying event*** or during ***open enrollment***.

If your premium deductions are on a pre-tax basis, you may disenroll your dependent within 31 calendar days of a ***qualifying event*** allowing a mid-year election, or during the ***open enrollment*** period Sandia holds each fall. You can also disenroll your dependent at any time during the calendar year if the disenrollment of the dependent does not affect your premium-share amount.

How to Disenroll Dependents

- Complete the dependent disenrollment form (SF 4400 DIS)
- Retain a copy for your files

- Mail the original, early enough to meet the 31-calendar-days criteria, to Sandia Benefits at Mail Stop 1022.

Important

If you are disenrolling a dependent due to a legal separation, an annulment, or a divorce, you must provide a copy of the first page of the legal document.

Benefits forms are available on Sandia's website under Corporate Forms/Benefits or by calling Sandia HBES at (505) 844-4237.

Note: You may disenroll a dependent without a ***mid-year election change*** event if you are NOT enrolled in the Pre-Tax Premium Plan.

Sandia abides by a federal law referred to as the Consolidated Omnibus Budget Reconciliation Act (***COBRA***) of 1985 in which temporary continued coverage is provided to dependents who would otherwise lose group coverage due to specified events. Refer to Section 13, Continuation of Group Health Coverage, for more information.

Note: Contact Sandia HBES at (505) 844-4237 for ***COBRA*** information.

Consequence of Not Disenrolling Ineligible Dependents

You must notify Sandia Benefits within 31 calendar days of the date that your dependent no longer meets the eligibility criteria for this Plan.

If you do not disenroll any ineligible dependent, Sandia may:

- Take employment disciplinary action up to and including termination for fraudulent use of the Plan
- Take action that results in permanent loss of health plan coverage for you and your dependents for fraudulent use of the Plan
- Report the incident to the Office of the Inspector General

and Sandia will:

- Retroactively terminate dependent coverage, effective the end of the month in which the dependent became ineligible
- Refund any applicable premium paid by you during the ineligible period
- Hold the primary ***covered member*** personally liable to refund to Sandia all medical plan benefits provided during the ineligible period
- Terminate any rights to temporary, continued health care coverage under ***COBRA***

HIPAA Rights

HIPAA provides rights and protections for participants and beneficiaries in group health plans. Under ***HIPAA***, if you waived or dropped coverage for yourself and your dependents because of other health insurance coverage, and you and/or your dependents involuntarily lose eligibility for that coverage, you may be able to enroll yourself and your eligible dependents during the plan year. You must request enrollment and notify Benefits, in writing, within 31 calendar days of your loss of coverage.

Important

If you are a surviving spouse and you waive or drop coverage, you can never reenroll in a ***Sandia-sponsored medical plan****.*

The eligible events that may allow a mid-year election to enroll in this Plan include:

- **Loss of eligibility under another plan.** An eligible ***employee or retiree*** (and/or his or her dependents) who declined coverage when initially eligible because of having other medical coverage, and who later loses the other coverage, may apply for coverage within 31 calendar days of the loss of coverage.
- ***COBRA*** **is exhausted after coverage under another medical plan.** An eligible ***employee or retiree*** (and/or his or her dependents) who has exhausted coverage under another medical plan outside of Sandia may apply for coverage within 31 calendar days of this event.
- **Employer contributions to other coverage ends.** An eligible ***employee or retiree*** (and/or his or her dependents) whose employer contributions to the other plan in which he or she is enrolled have ended may apply for coverage within 31 calendar days of the date the other coverage ends because of this event.
- **Exhausting a lifetime limit under another plan.** An eligible ***employee or retiree*** (and/or his or her dependents) who has exhausted coverage under another plan due to meeting lifetime limits may apply for coverage within 31 calendar days of the date coverage is denied due to meeting the lifetime limit.

In addition, if you acquire a new eligible dependent as a result of marriage, birth, adoption, placement for adoption, or obtaining legal guardianship, you may be able to enroll yourself and your eligible dependents. You must request enrollment and notify Sandia Benefits, in writing, within 31 calendar days of the effective date following the event.

Waiving or Dropping Coverage in Sandia-Sponsored Medical Plans

Important

If you are a surviving spouse and you waive or drop coverage, you can never reenroll in a ***Sandia-sponsored medical plan****.*

You have the option to waive or drop coverage for yourself and your dependents. You can waive coverage when you initially become eligible to enroll in the plan, or you can elect to drop coverage during the annual ***open enrollment*** period Sandia holds each fall.

Coverage for any eligible dependent is based on your coverage as a primary covered member; therefore, if you waive or drop coverage for yourself, you are also waiving or dropping coverage for all of your covered and/or eligible dependents. Coverage will end on the last day of the month in which you drop or waive coverage.

Except for the specific circumstances described in the remainder of this Section, the next opportunity for you to reinstate your coverage under this Plan will be during the annual ***open enrollment*** period Sandia holds each fall, with coverage becoming effective January 1 of the following year. You and/or your eligible dependents may also be eligible to reenroll based on a qualifying ***mid-year election change*** event. Refer to the Pre-Tax Premium Plan booklet for more information.

How to Waive or Drop Coverage

- Complete the waiver of medical coverage form (SF 4811-WMC)
- Retain a copy for your files
- Mail the original, early enough to meet the 31-calendar-days criteria or the end of the ***open enrollment*** period, to Benefits at Mail Stop 1022.

Benefits forms are available on Sandia's website under Corporate Forms/Benefits or by calling Sandia HBES at (505) 844-4237.

Coverage During Leaves of Absence

Employees meeting the requirements of FMLA have the option to cancel their coverage under this Plan. Written notification to cancel coverage must be received by Sandia Benefits, in writing, within 31 calendar days of the first day of absence. If you choose to cancel coverage, coverage will cease at the end of the month in which Sandia Benefits receives written notification. If you do not cancel the coverage, coverage will be continued and premiums will continue to be deducted (on a pre-tax or after-tax basis) during your absence, or made up upon your return from an unpaid absence.

Employees taking non-FMLA leave will receive paperwork from Sandia Benefits. If you wish to continue coverage under this Plan, you will be personally responsible for paying your monthly premiums on an after-tax basis. If you do not continue to pay your premiums during a non-FMLA leave, your coverage will be canceled.

If you do not cancel your coverage under this Plan during your ***leave of absence*** or an unpaid absence and you return in a subsequent calendar year, premiums not taken will be made up on an after-tax basis.

An employee can reenroll in this Plan by requesting enrollment and notifying Benefits, in writing, within 31 calendar days of returning to work from the ***leave of absence***. If you do not reenroll in this Plan by notifying Sandia Benefits, in writing, within 31 calendar days of your date of return from leave, you cannot reinstate your medical coverage until the following ***open enrollment*** period Sandia holds each fall.

Important

*If you have waived medical coverage for yourself and your dependents while still employed with Sandia and then terminated employment with Sandia without medical coverage, you and your dependents are not eligible for any **COBRA** continuation.*

Mid-Year Election Change Events

Certain events may permit a change to your medical coverage at times other than during ***open enrollment***. Refer to the Pre-Tax Premium Plan booklet for more information.

Note: Notify Sandia Benefits, in writing, within 31 calendar days of the ***mid-year election change*** event.

Section 4. Group Health Plan Premiums

This section outlines how premiums are charged according to the various classifications of ***members*** who are eligible for coverage under a Sandia-sponsored medical plan.

Benefits paid under a group medical plan for your covered dependents who would not qualify as a tax dependent under the ***IRC*** for purposes of medical coverage causes the primary ***covered member*** to receive additional compensation as taxable wages.

The primary ***covered member*** is required to declare as taxable income the value (imputed income) of the coverage for the non-eligible dependent. Imputed income is not a pay increase; it is the value of Sandia's contributions for medical coverage for dependents who are not your tax dependents. The imputed income will be added to your gross income and will be subject to income taxes and may be subject to FICA (Social Security and ***Medicare***). This amount will be reported on your annual W-2 form from Sandia or other appropriate reporting tax form.

The definition of tax dependent is set forth in the ***IRC***. If you have questions about whether your covered dependents are your tax dependents for purposes of medical coverage, consult with the IRS or your tax advisor.

If any of your covered dependents do not meet the definition of tax dependent, as set forth in the ***IRC*** for purposes of medical coverage, contact Sandia HBES at (505) 844-4237 to obtain a form to complete so that your dependents can be reflected correctly in the database. Refer to the Pre-Tax Premium Plan booklet for more information. In addition, in some instances, you will also have imputed income for those premiums in the calendar year attributable to your dependent not qualifying as your tax dependent as described herein.

Important

*It is the responsibility of each enrolled primary **covered member** to determine if his or her covered dependent meets the plan eligibility requirement of Sandia's medical plans and the tax dependent rules of the **IRC**. Should the **IRS** audit your tax return and determine you have obtained tax benefits for which you are not eligible, you will be responsible for any overdue taxes, interest, and penalties.*

Note: Contact Sandia HBES at (505) 844-4237 for assistance in disenrolling your dependent who does not qualify as a tax dependent under ***IRC*** Section 152 for purposes of medical coverage or for assistance in determining any taxable income.

Monthly Premium Payment for Coverage

In most instances, Sandia requires a monthly premium payment for coverage of eligible individuals under this Plan.

If you are required to pay a premium, the monthly amount will be deducted from:

- Employee's biweekly paycheck in two equal installments each month or
- Retiree's monthly pension check

Survivors have the option of paying the monthly premium share amount:

- From their monthly pension check
- Directly from their bank account or
- In a direct payment to Sandia

Other eligible covered persons pay Sandia:

- In a direct payment

Note: Health care premiums, whether taken on a pre- or after-tax basis, are not allowed as reimbursable expenses under the ***Health Care Reimbursement Spending Account***.

Employee Premium

The current year's premiums for employee medical coverage under this Plan are provided during the ***open enrollment*** period Sandia holds each fall prior to the start of the current plan year. Employees may also call Sandia HBES at (505) 844-4237 for rates.

All employees pay a monthly premium for coverage under this Plan. Premium payments are set according to the employee's base salary tier, coverage tier, the medical coverage offered by Sandia, and the coverage elected by the employee. The Class I dependent premiums are included in the employee premium share amount taken through payroll deduction. The amount is set according to which Sandia-sponsored medical coverage the employee selects for himself/herself and his/her eligible Class I dependents.

The premium share is based upon the following family structure:

- Employee only
- Employee and ***child(ren)***
- Employee and spouse
- Employee, spouse, and ***child(ren)***

Sandia currently has three salary tiers for premium share purposes:

- Tier 1 – Base salary of up to $75,000 as of January 1, 2006
- Tier 2 – Base salary of $75,001 to $150,000 as of January 2006
- Tier 3 – Base salary of over $150,000 as of January 1, 2006

The premium share for the calendar year is based on the employee's base salary as of January 1. If that base salary changes during the year and the employee is bumped into another tier, the premium-share will not change for the remainder of the calendar year.

Employees working on a part-time basis (at least 24 hours per week) pay the applicable premium share based on their pro-rated salary as of January 1; however, part-time employees working fewer than 24 hours per week will pay half of the full premium cost (regardless of when they began the work schedule of fewer than 24 hours per week).

Note: Represented employees need to refer to their union agreements for premium-sharing information.

If your effective coverage date is prior to the 17th of the month, you are required to pay the applicable cost-share amount for the month in which you became eligible for coverage under a ***Sandia-sponsored medical plan***. If your effective coverage date is on or after the 17th of the month, you are not required to pay the cost-share amount for the month in which you became eligible for coverage under a Sandia-sponsored medical plan.

Dual Sandians

If you are a Sandia employee married to another Sandia employee or to a Sandia retiree, you are considered a ***dual Sandian***. As a ***dual Sandian***, you may elect to cover yourself as (1) an individual, (2) a dependent of your Sandia spouse, or (3) as the primary covered employee or retiree, with your Sandia spouse as a dependent. If you, as the employee, are the primary ***covered member***, cost-sharing of monthly premiums will be based on your salary tier. If you and your Sandia spouse elect to be covered separately, any eligible dependents may be covered under either spouse (i.e., some dependents may be enrolled under one spouse while other dependents are enrolled under the other spouse.) No dependents may be covered under both Sandians simultaneously.

Note: Under this Plan, employees, retirees, or eligible dependents cannot be covered as both a primary ***covered member*** and a dependent, or as a dependent of more than one primary ***covered member***.

Employees, retirees, or other qualifying individuals who are covered in any other ***Sandia-sponsored medical plans*** are not eligible to participate in this Plan. You have the option to change your ***Sandia-sponsored medical plan*** choice once a year during the ***open enrollment*** period Sandia holds each fall.

Domestic Partner Premium

For medical coverage purposes under the IRC, benefits for a covered ***domestic partner*** or for covered dependents of a ***domestic partner*** who do not qualify as a tax dependent under the IRC causes the employee to receive additional compensation as taxable wages.

The employee is required to declare as taxable income the value (imputed income) of the ***domestic partner***'s and ***domestic partner's*** dependent coverage. Imputed income is not a pay increase; it is the value of Sandia's contributions for medical coverage for dependents who are not your tax dependents. The imputed income will be added to the employee's gross income and will be subject to income tax and may be subject to FICA (Social Security and Medicare). This amount will be reported on the employee's annual W-2 form from Sandia or other appropriate reporting tax form.

> **Note:** Medical coverage premiums for your domestic partner and/or your domestic partner's dependents will be automatically deducted on an after-tax basis. Imputed income will be included in the employee's income UNLESS you contact Sandia Benefits and complete an Affidavit of Tax Status to allow those dependents discussed above to be designated as tax dependents under ***IRC*** 152 for medical coverage purposes.

If you have any questions and/or for information on specific domestic partner's premium-sharing provisions, refer to the Domestic Partner packet on the Benefits internal website or contact Sandia HBES at (505) 844-4237 to obtain a packet.

Pre-Tax Premium Plan

The Pre-Tax Premium Plan allows employees to take advantage of the tax savings generated by having any required medical coverage premiums taken out of their paychecks before federal, state, and social security (FICA) taxes are deducted. Your taxable income is reduced because your premiums are not included as income. This is allowable under Section 125 of the ***IRS*** Code. Once the calendar year begins, you generally cannot change the tax status (from pre-tax to after-tax and vice versa) of your premium share.

Due to ***IRS*** rules governing pre-tax premiums, individuals not qualifying as tax dependents under ***IRC*** for purposes of medical coverage must be enrolled individually and cannot be combined as part of the Employee and Spouse; Employee and Child(ren); or Employee, Spouse, and Child(ren) coverage.

Separate monthly premiums must be paid to cover these individuals on an after-tax basis. If your dependent becomes ineligible as your tax dependent under the ***IRC*** for medical coverage purposes, but he or she is still eligible under this medical Plan, your pre-tax premiums attributable to that dependent's medical coverage will be changed to after-tax.

You may not pay any portion of medical coverage premiums on a pre-tax basis for a dependent who does not qualify as your tax dependent for medical coverage purposes. If you would prefer to drop this dependent, you will be able to do so.

Note: Check your pay stub to determine whether premiums are being taken on a pre-tax or after-tax basis.

Important

*You must notify Sandia Benefits of premiums being taken on a pre-tax basis for your Class I dependents who do not meet the dependent criteria of Section 152 of the **IRC** for medical coverage purposes. The medical coverage premiums (if applicable) for these dependents will need to be paid on an after-tax basis, and you will have imputed income.*

If your dependent does not meet the eligibility criteria for plan coverage, you must disenroll him or her within 31 calendar days of becoming ineligible. Refer to the Pre-Tax Premium Plan booklet for more information.

Leaves of Absence

Child and Family Care. Sandia pays the employer portion of the premiums for continued medical coverage under this Plan during the first six months of your leave. You will pay the full premium for continued medical coverage beyond the first six months.

If you do not continue your medical coverage under this Plan during your leave, you will need to reenroll to reinstate your medical coverage under this Plan.

Tribal Government Appointee. Sandia pays the employer portion of the premiums for continued medical coverage under this Plan during the period of this leave.

If you do not continue your medical coverage under this Plan during your leave, you will need to reenroll to reinstate your medical coverage under this Plan.

Military Service. Sandia pays the employer portion of the premiums for continued medical coverage during the first six months of your leave. You will pay the full premium for continued medical coverage beyond the first six months.

If you do not continue your medical coverage under this Plan during your leave, you will need to reenroll to reinstate your medical coverage under this Plan.

Other. Your medical coverage under this Plan stops at the end of the month in which your leave begins. You are eligible to continue your medical coverage under this Plan by paying the full premium for the duration of your approved leave.

If you do not continue your medical coverage under this Plan during your leave, you will need to reenroll to reinstate your medical coverage under this Plan.

Premiums for Retiree Medical Plan Option

The current year's premiums for retiree medical coverage under this Plan are provided during the ***open enrollment*** period Sandia holds each fall prior to the start of the current plan year. Retirees may also contact Sandia HBES at (505) 844-4237 for premium rates.

Sandia currently pays the full amount of coverage for you and your covered dependents during retirement, if you retired with a service pension, as follows:

- Between August 8, 1977, and January 1, 1988, at age 64 or older, with at least **10** years of service as of age **65**
- Before January 1, 1988, with at least **15** years of service
- Between January 1, 1988, and December 31, 1994, with a service or disability pension

Retirees who retired with a service or disability pension after December 31, 1994, will share in the cost of coverage in this Plan. The current cost-sharing is as follows:

- Retirees who retired after December 31, 1994, and before January 1, 2003, will pay 10 percent of the experience-rated premiums
- Retirees who retired after December 31, 2002, will pay a percentage of the experience-rated premiums based on their term of employment as follows:
    - 30+ years – 10 percent
    - 25 to 29 – 15 percent
    - 20 to 24 – 25 percent
    - 15 to 19 – 35 percent
    - 10 to 14 – 45 percent

Retirees who do not meet any of the above conditions may continue coverage under this Plan by paying the full cost of coverage under ***COBRA***. Refer to Section 13, Continuation of Group Health Coverage, for more information.

Dual Sandians

If you are a Sandia retiree married to another Sandia retiree or to a Sandia employee, you are considered a ***dual Sandian***. As a ***dual Sandian***, you may elect to cover yourself as (1) an individual, (2) a dependent of your Sandia spouse, or (3) as the primary covered employee or retiree, with your Sandia spouse as a dependent. If you, as the retiree, are the primary ***covered member***, cost-sharing of monthly premiums will be based on retiree status. If you and your Sandia spouse elect to be covered separately, any eligible dependents may be covered under either spouse (i.e., some dependents may be enrolled under one spouse while other dependents are enrolled under the other spouse.) No dependents may be covered under both Sandians simultaneously.

Note: Under this Plan, employees, retirees, or eligible dependents cannot be covered as both a primary ***covered member*** and a dependent, or as a dependent of more than one primary ***covered member***.

Employees, retirees, or other qualifying individuals who are covered in any other ***Sandia-sponsored medical plans*** are not eligible to participate in this Plan. You have the option to change your ***Sandia-sponsored medical plan*** choice once a year during the ***open enrollment*** period Sandia holds each fall.

Premiums for Long-Term Disability (LTD) Terminees

The current year's premiums for continued medical coverage for long-term disability (LTD) terminees under this Plan are provided during the ***open enrollment*** period Sandia holds each fall prior to the start of the current plan year. LTD terminees may also contact Sandia HBES at (505) 844-4237 for premium rates.

If you became an LTD terminee before January 1, 2003, you pay 10 percent of the full experience-rated premium for you and your covered dependents.

If you became an LTD terminee after December 31, 2002, you pay 35 percent of the full experience-rated premium for you and your covered dependents.

Premiums for Surviving Spouse Medical Plan Option

Survivors of regular Sandia employees or retirees are eligible for continuation of coverage under the Surviving Spouse Medical Plan by paying the monthly premium.

IMPORTANT

If you are a surviving spouse and you waive or drop coverage, you can never reenroll in a Sandia-sponsored medical plan.

The survivor premium payments for the first six months will be at the rate the employee or retiree was paying for coverage at the time of death. After the initial six months, the survivor (and any dependents covered by this Plan at the time of death) may continue coverage by paying:

- 50 percent of the full experience-rated premium if you are a survivor of a retiree or a regular employee with 15 years or more term of employment
- 100 percent of the full experience-rate premium if you are a survivor of a regular employee with less than 15 years term of employment.

Your decision for continuation of coverage under the Surviving Spouse Medical Plan Option must be made prior to the expiration of the initial six-month coverage.

The applicable survivor rate will depend on the health care plan under which you are covered and whether coverage is for single coverage or family coverage.

Coverage under the Surviving Spouse Medical Plan Option will terminate for the surviving spouse and dependents if:

- Surviving spouse remarries

Note: If the surviving spouse remarries, he or she does not have ***COBRA*** rights to continue coverage; however, any covered dependents that would lose coverage as a result of the remarriage would have ***COBRA*** rights.

- Payments are not received when due
- Surviving spouse dies

Note: If the surviving spouse dies less than 36 months after the employee or retiree death, the covered dependents may have rights to continue ***COBRA*** coverage.

The primary ***covered member*** is responsible for any claims paid on his or her behalf and any dependents' behalf as of the date of ineligibility. Contact Sandia HBES at (505) 844-4237 for more information.

COBRA Premium

Sandia requires individuals who elect continuation of the employer-provided medical coverage to pay the full cost of the coverage, plus a two percent administrative charge. The required ***COBRA*** premium is more expensive than the amount that active employees are required to pay, but the ***COBRA*** premium may be less expensive than individual medical coverage. ***COBRA*** continuation coverage lasts only for a limited period of time. See Section 13, Continuation of Group Health Coverage, for more information.

As an alternative to electing medical coverage under the Retiree, LTD Terminee, or Surviving Spouse Medical Plan Options, those individuals may choose to continue the active employee medical coverage by making a ***COBRA*** election. See Section 13, Continuation of Group Health Coverage, for more information.

Section 5. Deductibles and Maximums

The following table summarizes annual ***deductibles***, annual ***out-of-pocket maximums***, and lifetime maximums that may apply under this CIGNA In-Network Plan.

Type	CIGNA In-Network Plan	
	Individual	Family
Deductible	None	None
Out-of-Pocket Maximum	$1,500	$3,000
Lifetime Maximum Coverage	None	None

Payments Applied to Out-of-Pocket Annual Maximum

Copays under the CIGNA In-Network Plan apply to the annual ***out-of-pocket maximum***, except for prescription drugs ***copays***.

Each covered family member may contribute toward the family ***out-of-pocket maximum***. However, contribution maximums are limited to the individual ***out-of-pocket maximum***.

Payments Not Applied to Out-of-Pocket Annual Maximum

The following payments do NOT apply to ***out-of-pocket maximums***:

- Expenses in the Prescription Drug Program
- Penalties caused by failure to obtain pre-certification
- Expenses not covered by the Plan

Out-of-Pocket Maximums for Employees

With some exceptions (listed below), no additional ***copays*** will be required for the remainder of the calendar year as follows:

- For the ***member***, when he/she has incurred his or her ***out-of-pocket maximum*** for covered medical expenses
- For the family, when they have incurred their ***out-of-pocket maximum*** for covered medical expenses.

CIGNA HealthCare will notify ***members*** via an explanation of benefits (EOB) statement when the ***out-of-pocket maximum*** has been reached. The following table identifies what does and does not apply toward annual ***out-of-pocket maximums***:

Plan Features	Applies to Annual Out-of-Pocket Maximum
Copays	Yes
Payments toward the annual deductible	Not applicable
Charges for noncovered health services	No
Amounts of any reductions in benefits you incur by not following prior authorization or pre-certification requirements	No
Amounts you pay toward behavioral health services	Yes
Outpatient prescription drugs	No

Example: In a calendar year, a family of three meets the CIGNA In-Network Plan's family $3,000 ***out-of-pocket maximum*** as follows:

In-Network Plan Out-of-Pocket Maximum		
	Out-of-Pocket Expenses	**Applied to Out-of-Pocket**
Employee	$1,500	$1,500
Spouse	$1,500	$1,500
1st Child	$0	$0
Total:	**$3,000**	**$3,000**

For the remainder of the calendar year, any additional medical expenses submitted by this family will be paid at 100 percent of the ***covered charges*** (with some exceptions).

Out-of-Pocket Maximums for Non-Medicare Primary Retirees/Survivors/LTD Terminees

With some exceptions (listed below), no additional ***copays*** will be required for the remainder of the calendar year:

- For the ***member***, when he/she has incurred his or her annual ***out-of-pocket maximum*** for covered medical expenses
- For the family, when they have incurred their annual ***out-of-pocket maximum*** for covered medical expenses

CIGNA HealthCare will notify ***members*** via an EOB statement when the ***out-of-pocket maximum*** has been reached. The following table identifies what does and does not apply toward CIGNA In-Network Plan ***out-of-pocket maximums***.

Plan Features	Applies to Annual Out-of-Pocket Maximum
Copays	Yes
Coinsurance payments	Not applicable
Charges for noncovered health services	No
Amounts of any reductions in benefits you incur by not following prior authorization or pre-certification requirements	No
Amounts you pay toward behavioral health services	Yes
Charges that exceed usual and customary	Not applicable
Outpatient prescription drugs	No

Example: In a calendar year, a family of two meets the in-network plan's family $3,000 ***out-of-pocket maximum*** as follows:

In-Network Plan Out-of-Pocket Maximum		
	Out-of-Pocket Expenses	**Applied to Out-of-Pocket**
Retiree	$1,500	$1,500
Spouse	$1,500	$1,500
Total:	**$3,000**	**$3,000**

For the remainder of the calendar year, any additional covered medical expenses submitted by this family under this Plan will be paid at 100 percent of the ***negotiated fee*** (with some exceptions).

Lifetime Maximums

The lifetime maximum for intensive ***outpatient*** stay is three programs under the ***behavioral health*** benefit.

Section 6. Coverages and Limitations

What this CIGNA In-Network Plan Covers

This Plan provides a wide range of medical care services for you and your family. All coverage is based on medical necessity and whether the service is a ***covered health service***.

This Plan provides coverage for in-network care only from network ***providers*** contracted with CIGNA HealthCare; it does not provide for ***out-of-area coverage***.

The out-of-network option is not available under this Plan except for emergencies and ***urgent care*** needs.

This Plan does not have any preexisting condition limitations. This means, for example, that if you have a condition such as pregnancy or cancer before you begin coverage under this plan, you are not required to wait a specific amount of time before you are covered under this Plan.

Covered health services are those health services and supplies that are:

- Provided for the purpose of preventing, diagnosing, or treating ***illness***, ***injury***, mental illness, ***substance abuse***, or their symptoms
- ***Medically necessary***
- Included in this section
- Provided to a ***covered member*** who meets the Plan's eligibility requirements, as described in Section 2, Eligibility.

Plan Highlights

The following tables highlight the amounts you will pay for various covered medical services. A ***copay*** is a defined dollar amount (e.g., $15 ***copay*** for a primary care physician office visit) that the ***covered member*** pays for services rendered, and the Plan pays the remainder of the ***covered charges*** from ***participating providers*** and facilities.

Benefit	CIGNA In-Network Plan
Important For detailed benefit provisions, please refer to the information following this table.	
Acupuncture (see short-term rehabilitation therapies)	$15 copay per visit
Allergy Services	
– office visit – testing – serum – allergy shot	$25 copay per visit $25 copay per visit No copay $10 copay per visit
Ambulance	$50 copay per trip
Behavioral Health (inpatient care includes hospital, physicians, and other professional services)	**Preadmission Certification Required**
Mental Health:	
– inpatient	$200 per day up to $500 per admission (maximum of 45 days per calendar year)
– intensive outpatient stay	$250 per program (three programs lifetime maximum with each day applied to 45 days maximum for inpatient mental health)
– outpatient	$25 copay per visit (maximum of 30 visits per calendar year)
Substance Abuse:	
– inpatient	$200 per day up to $500 per admission (maximum of 15 days per calendar year)
– intensive outpatient stay	$250 per program (three programs lifetime maximum with each day applied to 15 days maximum for inpatient substance abuse)
– outpatient	$25 copay per visit (maximum of 30 visits per calendar year)
Biofeedback Services	$25 copay per visit
Chemotherapy	No charge
Chiropractic Services (see short-term rehabilitation therapies)	$15 copay per visit
Dental Services	
– physician's office – outpatient facility – inpatient facility	$25 copay per visit $100 copay per visit $200 per day up to $500 per admission
Diagnostic Tests (outpatient)	No charge

Benefit	CIGNA In-Network Plan
Important For detailed benefit provisions, please refer to the information following this table.	
Durable Medical Equipment (DME)	No charge
Emergency Room Care	$100 copay per visit
Employee Assistance Programs	No charge for up to eight visits per year maximum
External Prosthetic Appliances	$200 deductible, then no charge
Eye Exam for non-refractive care due to sudden illness or injury to the eye	$15 PCP copay per visit $25 specialist copay per visit
Eyeglasses/Contact Lenses (initial pair only when required due to the loss of a natural lens)	See DME benefit
Family Planning	$15 PCP copay per visit $25 specialist copay per visit
Hearing Aids/Exam	See DME benefit and/or per office visit co-pay
Home Health Care	No copay
Hospice Services	No Copay
Infertility Treatment	**Not available under this Plan**
Injections in physician office (other than those covered under Preventive Care or allergy shot)	$15 PCP copay per visit $25 specialist copay per visit
Inpatient Services	$200 per day up to $500 per admission
Lab (outpatient)	No charge
Maternity – initial visit to determine pregnancy status – prenatal and postnatal care – delivery – nursery care for well-baby newborn	 $15 copay No copay $200 per day up to $500 per admission No copay
Nutritional Counseling	$15 copay per visit
Occupational Therapy (see short-term rehabilitation therapies)	$15 copay per visit
Office Care/Visits – primary care physician – specialist	 $15 copay per visit $25 copay per visit
Organ Transplant	$200 per day up to $500 per admission

Benefit	CIGNA In-Network Plan
Important For detailed benefit provisions, please refer to the information following this table.	
Outpatient Surgery – physician's office – outpatient facility	 $25 copay $100 copay
Physical Therapy (see short-term rehabilitation therapies)	$15 copay per visit
Prescription dispensed other than at pharmacy (i.e., physicians office)	No copay
Preventive Care	No charge
Prosthetic Appliances	See DME benefit
Radiology	No charge
Radiation Therapy	No charge
Rehabilitation Hospital (combined maximum with skilled nursing facility of 60 days per calendar days)	No copay
Skilled Nursing Facility (combined maximum with rehabilitation hospital of 60 days per calendar days)	No copay
Short-Term Rehabilitation Therapies (outpatient) – acupuncture – chiropractic – occupational – physical – speech (combined therapies listed here — 60 visits per calendar-year benefit)	$15 copay per visit
Speech Therapy (see short-term rehabilitation therapies)	$15 copay per visit
Supplies	No copay
Urgent Care Facilities	$40 copay per visit
Important *For detailed benefit provisions, refer to the information following this table.*	

Coverage Details

While the table above provides you with information about the coverage levels, the following information provides detailed descriptions of the covered services.

Acupuncture Services (Prior Authorization Required)

See Short-Term Rehabilitation for combined annual benefit maximum.

- Includes x-rays and other services provided by a licensed acupuncturist or licensed doctor of oriental medicine.

Ambulance Services

The Plan covers ambulance services and transportation provided by a licensed ambulance as follows:

- ***Emergency*** ground ambulance services:
    - for ***emergency*** transportation to the nearest ***hospital*** where ***emergency*** health services can be performed
    - transportation from one facility to another is considered as ***emergency*** when ordered by the treating physician
    - if there is documentation from the ambulance service provider that it does not differentiate between advanced life support and basic life support, the Plan will cover the service as billed
- ***Emergency*** air ambulance services:
    - air ambulance is covered only when ground transportation is impossible or would put life or health in serious jeopardy
    - ***the patient*** may be transported by air ambulance to a facility nearest to his or her established home address if the ***member***'s condition precludes his or her ability to travel by a nonmedical transport
    - if the person is in line for a transplant and the transplant has been approved by the CIGNA LIFESOURCE Transplant Case Management and there are no commercial flights to the city where the organ is available, the Plan will cover the medical transport of the patient via air ambulance or a jet (whichever is less expensive)

If there is no in-network ambulance service available, the ambulance will be covered at the in-network level of benefit.

Other than what is listed above, ***nonemergency*** ambulance services are not covered.

Behavioral Health Services

The Plan covers ***outpatient*** mental health and ***substance abuse*** services as follows:

- evaluations and assessments
- diagnosis
- treatment planning

- referral services
- medication management
- individual and group therapeutic services
- intensive outpatient therapy programs
- crisis intervention
- psychological testing including neuropsychological testing

Prior authorization is not required for ***outpatient*** mental health and ***substance abuse*** services unless it is an intensive ***outpatient*** program or it is neuropsychological testing.

The Plan covers ***inpatient*** and ***partial hospitalization*** mental health and ***substance abuse*** services as follows:

- services are required to be preauthorized by CIGNA Behavioral Health (otherwise you incur a $300 penalty) and
    - received on an ***inpatient*** or ***partial hospitalization*** basis in a licensed ***hospital*** or an alternate licensed facility that provides mental health or ***substance abuse*** treatment
- If there are multiple diagnoses, the plan will only pay for treatment of the diagnoses that are identified in the current edition of the *Diagnostic and Statistical Manual* of the American Psychiatric Association (APA).
- Residential rehabilitation at a licensed residential treatment facility with at least six hours of therapy provided.
- If a ***member*** is admitted to a facility and the patient does not meet ***inpatient*** criteria, CIGNA Behavioral Health will review to determine whether the patient meets partial hospitalization criteria. If the ***member*** does meet the partial hospitalization criteria, only the cost for partial hospitalization in that area will be allowed, with the covered member responsible for the remainder of the cost.
- Wilderness programs, boot-camp-type programs, work-camp-type programs or recreational-type programs are **not** covered.
- If CIGNA Behavioral Health determines that an ***inpatient*** stay is required, it is covered on a semi-private room basis (a room with two or more beds).
- If CIGNA Behavioral Health determines that partial hospitalization is required, two partial hospitalization days are counted as one 24-hour hospitalization day.
- Types of services that are rendered as a medical service, such as lab or radiology services, are paid under the medical benefits.

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Biofeedback Services (Prior Authorization Required)

The Plan covers biofeedback services as follows:

- for pain, urinary, and fecal incontinence
- up to five sessions per lifetime for smoking cessation
- for training
- billed by a licensed ***provider***, including chiropractor, physical therapist, occupational therapist, medical doctor or doctor of osteopathy—charges from other ***providers*** will be reviewed for medical necessity

Cancer Services

For oncology services and supplies to be considered ***covered health services***, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. The Plan covers oncology services as follows:

- Office visit
- Professional fees for surgical and medical services
- ***Inpatient*** services
- ***Outpatient*** surgical services

Chiropractic Services (Prior Authorization Required)

See Short-Term Rehabilitation for combined maximum.

- Includes X-rays and other services provided by an in-network licensed chiropractor or doctor of oriental medicine.

Dental Services (Prior Authorization Required)

The Plan covers dental services when provided by licensed ***providers***, including doctor of dental surgery (DDS) or doctor of medical dentistry (DMD), as follows:

- Services incurred as a result of accidental injury to sound, natural teeth and the jaw
- Tooth or bone loss due to a medical condition (e.g., osteoporosis, radiation to the mouth, etc.)
- Oral surgery if performed in a ***hospital*** because of a complicating medical condition that has been documented by the attending physician
- Anesthesia, ***hospital***, and/or ambulatory surgical center expenses for dental procedures when services must be provided in that setting due to disability or for young children as determined by the attending physician
- Dental implants and implant-related surgery are covered in situations where:

    - permanent teeth are congenitally missing (anodontia), the result of anodontia is impaired function (e.g., chewing/eating), and the implants are not done solely for cosmetic reasons
    - tooth loss occurs as a result of accidental injury
    - tooth loss occurs due to a medical condition such as osteoporosis or radiation of the mouth
- Orthognathic surgery limited to documented skeletal Class II and Class III conditions as determined by cephalometric diagnosis, provided the condition:
    - is both functional and esthetic
    - is not, in the opinion of CIGNA HealthCare, adequately treatable by conventional orthodontic therapy
- Dental services related to medical transplant procedures
- Initiation of immunosuppressive therapy
- Direct treatment of cancer or cleft palate

For services that are provided as a result of an accident, initial treatment must have been started within one year of injury (regardless of whether you were covered under a Sandia medical plan or another employer plan at the time).

Dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not covered.

Although dental implants and implant-related surgery may be covered as indicated above, any crowns or other prosthesis required as a result of the implant are not covered. These may be covered under the Sandia Dental Deluxe/Expense Plans.

Diagnostic Tests (Prior Authorization Required)

The Plan covers diagnostic tests as follows:

- Lab and radiology
- Computerized tomography (CT) scans
- Position emission tomography (PET) scans
- Magnetic resonance imaging (MRI)
- Nuclear medicine
- Echocardiograms
- Electroencephalograms
- Sleep studies
- Other diagnostic tests

Durable Medical Equipment (DME) (Prior Authorization Required)

The Plan covers ***DME*** as follows:

- Ordered or provided by a physician for ***outpatient*** use
- Used for medical purposes
- Not consumable or disposable
- Not of use to a person in the absence of a ***illness***, ***injury***, or disability
- Durable enough to withstand repeated use
- Appropriate for use in the home

Examples of ***DME*** include items such as:

- Wheelchairs
- ***Hospital*** beds
- Equipment for the treatment of chronic or acute respiratory failure or conditions
- Equipment to administer oxygen
- Oxygen
- Orthopedic shoes
    - Up to two pairs of custom-made orthopedic shoes per year when necessary due to ***illness*** such as diabetes, post polio, or other such conditions
- Mastectomy bras
    - Up to two per calendar year following a mastectomy
    - Two devices of the combination type of two of the "sold separately" type. Under sold separately, the prosthesis would not be allowed for replacement
- C-PAP machine
- Bilirubin lights

The Plan will allow one educational training session to learn how to operate the ***DME***, if required. Additional sessions will be allowed if there is a change in equipment.

The Plan will allow more than one piece of ***DME*** if deemed medically appropriate by CIGNA HealthCare (e.g., an oxygen tank in the home and a portable oxygen tank).

CIGNA HealthCare will decide if the equipment should be purchased or rented, and you must purchase or rent the ***DME*** from the vendor CIGNA HealthCare identifies.

Benefits are provided for the replacement of a type of ***DME*** once every three years, except as otherwise stated above.

If the ***DME*** is purchased/owned, and it is lost or stolen, the Plan will not pay for replacement unless the ***DME*** is at least three years old. If the ***DME*** is leased/rented, the Plan will not pay for replacement; however, some rental agreements may cover it if lost or stolen. If the ***DME*** breaks or is otherwise irreparable as a result of normal use, the Plan will pay for a replacement.

Emergency Care (Prior Authorization Required)

If you have a medical ***emergency***, go to the nearest ***hospital emergency*** room. These facilities are open 24 hours a day, seven days a week.

This Plan will cover ***medical emergency*** care worldwide as follows:

- Reimbursement for ***emergency*** care will not be denied if, in good faith and with average knowledge of health and medicine, you seek ***emergency*** care for an ***illness*** that you believe is an acute condition that requires immediate medical attention. CIGNA HealthCare will take the following factors into consideration in determining if the ***illness*** or condition is reimbursable as ***emergency*** care:
    - A reasonable person's belief that the circumstances required immediate medical care that could not wait until the next working day or next available appointment
    - The time of day the care was provided
    - The presenting symptoms
    - ***Emergency*** services that meet the above criteria that are obtained from an out-of-network ***provider*** will be covered by the in-network level of benefit
    - ***Nonemergency*** services that are received in an in-network ***hospital emergency*** room will be covered at the applicable level of benefit
    - ***Nonemergency*** services that are received in an out-of-network ***hospital emergency*** room will not be covered by this Plan
    - If you are outside the United States and receive ***emergency*** care, you will be eligible for reimbursement at the in-network level of benefits
    - ***Follow-up care*** that results from a ***medical emergency*** while on travel, if you are outside the United States, will be covered by the in-network level of benefit
    - ***Follow-up care*** while on travel within the United States will be covered only from a network ***provider***
    - If you are hospitalized in an out-of-network ***hospital***, you will be transferred to an in-network ***hospital*** when medically feasible with

any ground ambulance charges covered in full. If you decline to be transferred, coverage will not be provided by this Plan.

- Expenses for health care services that you should have received before leaving the ***service area*** or that could have been postponed safely until your return will not be covered by this Plan.

Employee Assistance Program (Prior Authorization Required)

This Plan covers up to eight visits per calendar year at no cost to the ***covered member*** when obtained in-network for assessment, referral, and follow-up counseling for employees and their covered dependents experiencing impairment from personal concerns that adversely affect their day-to-day activity. These concerns include:

- Health
- Marriage
- Family
- Finances
- ***Substance abuse***
- Legal issues
- Stress

Important

Retirees, survivors, LTD terminees, and VSIP participants and their covered dependents are not eligible for EAP benefits.

Eye Exam/Eyeglasses/Contact Lenses

This Plan covers eye exams for non-refractive care due to ***illness*** or ***injury*** of the eye such as conjunctivitis, diabetic retinopathy, glaucoma, and cataracts. This Plan pays for an initial pair of contact lenses or glasses when required due to the loss of a natural lens or cataract surgery.

Family Planning

This Plan covers family planning services as follows:

- Sterilization procedures such as vasectomies and tubal ligations
- ***Medically necessary*** ultrasounds and laparoscopies
- Family planning devices that are implanted or injected by the physician such as intrauterine devices, Norplant, or Depo-provera
- Reversals of prior sterilizations

- Surgical, nonsurgical, or drug-induced pregnancy termination
- Health services and associated expenses for elective and therapeutic abortion

Diaphragms and any other birth control obtained at a pharmacy are eligible for coverage under the Prescription Drug Program.

Hearing Aids/Exam

The Plan will cover the initial hearing exam and hearing aid purchase if hearing loss results from a sudden ***injury*** or ***illness***. Natural hearing loss is not covered. Refer to the Preventive Care section for information on hearing screenings.

Home Health Care Services (Prior Authorization Required)

Covered health services are services that a home health agency provides if you are homebound due to the nature of your condition. Services must be:

- Ordered by a physician
- Provided by or supervised by a registered nurse in your home
- Not considered custodial in nature
- Provided on a part-time, intermittent schedule when skilled home health care is required

Hospice Services (Prior Authorization Required)

Hospice care is an integrated program, recommended by a physician, that provides comfort and support services for the terminally ill. ***Hospice*** care can be provided on an ***inpatient*** or ***outpatient*** basis and includes physical, psychological, social, and spiritual care for the terminally ill person, and short-term grief counseling for immediate covered family members. Benefits are available only when ***hospice*** care is received from a licensed ***hospice*** agency.

Infertility Services

Infertility services are not covered under the CIGNA In-Network Plan.

Inpatient Care (Prior Authorization Required)

An ***inpatient*** stay is defined as a ***hospital*** stay of 24 hours or more. If a ***hospital*** stay is billed as ***inpatient*** with charges for room and board, it will be considered ***inpatient*.** If a ***hospital*** stay is billed as ***outpatient***, no

room and board charges will be considered.

The Plan covers ***inpatient*** care in a ***hospital*** as follows:

- Services and supplies received during an ***inpatient*** stay
- Room and board in a semi-private room (a room with two or more beds)
- Intensive care

The Plan will pay the difference in cost between a semi-private room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for an ***inpatient*** stay in a ***hospital*** are available only when the ***inpatient*** stay is necessary to prevent, diagnose, or treat an ***illness*** or ***injury***.

Maternity Services

Newborn and Mother's Health Protection Act: Under federal law, mothers and their newborns who are *covered* under group health plans are guaranteed a stay in the *hospital* of no less than 48 hours following a normal delivery or not less than 96 hours following a cesarean section.

Prior authorization is **ONLY** required if you stay will be longer than 48 hours following a normal delivery or longer than 96 hours following a cesarean section.

The Plan pays for maternity services:

- Initial visit to the physician to determine pregnancy status
- Prenatal and postnatal visits
- Charges related to delivery
- Charges for newborn delivery services, which are paid as follows:
    - Charges billed for well-baby care are paid under the mother's benefit, subject to her ***out-of-pocket maximum***
    - Charges billed for the newborn under any other non-well-baby ICD-9 code are paid under the newborn and subject to ***out-of-pocket maximum***

Note: The Plan will pay for covered medical services for the newborn for the first 31 calendar days of life under the Plan (if the newborn would be eligible to be a Class I dependent). This is regardless of whether the primary ***covered member*** enrolls the dependent within 31 calendar days for continued coverage under this Plan.

The Plan will pay for maternity services for ***covered members*** (primary ***covered member***, the covered spouse, the covered ***domestic partner***, and covered dependent ***children***).

Licensed birthing centers are covered under the Plan to include charges from the birthing center, physician, midwife, surgeon, assistant surgeon (if ***medically necessary***), and anesthesia.

Benefits for birthing services rendered in the home will be paid according to the network status of the physician with whom the licensed nurse midwife is affiliated. If the licensed nurse-midwife is not affiliated with an in-network physician and is not a part of the network, coverage is not available under the Plan.

If you are admitted to a ***hospital***, you must notify CIGNA HealthCare within two business days or as soon as reasonably possible.

Important

Remember to add your newborn child(ren) to your medical coverage with Sandia Benefits, in writing, within 31 calendar days of the birth to continue coverage beyond the first 31 calendar days. If the newborn is not added to your medical coverage within 31 calendar days, any expenses billed under the newborn will not be covered.

Medical Supplies

The Plan covers certain medical supplies to include items such as:

- Ostomy supplies
- Therapeutic devices and appliances, such as blood glucose monitors, respiratory therapy devices, etc.
- Lancet auto-injectors
- Insulin pumps
- Compression stockings

Obtain lancets, alcohol swabs, diagnostic testing agents, syringes, novopen and insulin auto-injectors, and allergic emergency kits through the Prescription Drug Program.

Nutritional Counseling

The Plan covers certain services provided by a registered dietician in an individual session if you have a medical condition that requires a special diet. Some examples of such medical conditions include:

- Diabetes mellitus
- Coronary artery disease

- Congestive heart failure
- Gout (a form of arthritis)
- Renal failure
- Phenylketonuria (a genetic disorder diagnosed at infancy)
- Hyperlipidemia (excess of fatty substances in the blood)

Obesity Surgery (Prior Authorization Required)

The Plan covers surgical treatment of ***morbid obesity*** received on an ***inpatient*** basis provided all of the following are true:

- You have a minimum Body Mass Index (BMI) of 40
- You have documentation from a physician of a diagnosis of ***morbid obesity*** for a minimum of five years
- You are over the age of 21

Occupational Therapy (Prior Authorization Required)

See Short-Term Rehabilitation for combined maximum.

- Includes x-rays and other services provided by an in-network licensed therapist or doctor of oriental medicine.

Office Care/Visits

The Plan pays for the following services provided in the physician's office at the applicable office visit ***copay***:

- Allergy testing
- Chemotherapy
- Consultations
- Diagnostic tests
- Laboratory services
- Office surgery

  Note: Any anesthesia done in conjunction with surgery that is performed in a physician's office will be reimbursed down to the copay. For example, if you have a surgical procedure done in a physician's office and the physician bills for anesthesia in conjunction with that surgery you will incur a copay for the surgery and a copay for the anesthesia. Any medical supplies used in conjunction with the surgery performed in a physician's office will be reimbursed at 100 percent of eligible expenses.

- Post-operative follow up

- Radiation therapy
- Radiology services
- Second opinions
- Services after hours and ***emergency*** office visits
- Supplies dispensed by the provider

Organ Transplants (Prior Authorization Required)

The Plan covers ***inpatient*** facility services (including evaluation for transplant, organ procurement, and donor searches) for the following transplantation procedures when the transplant meets the definition of a ***covered health service*** and is not ***experimental***, ***investigational***, or unproven:

- Heart
- Heart/lung
- Lung
- Kidney
- Kidney/pancreas
- Liver
- Liver/kidney
- Liver/intestinal
- Pancreas
- Intestinal
- Bone marrow (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a ***covered health service*** (see below).

The search for bone marrow/stem cells from a donor who is not biologically related to the patient is a ***covered health service***. If a separate charge is made for a bone marrow/stem cell search, the Plan will pay up to $25,000 for all charges made in connection with the search.

Outpatient Surgical Services

The Plan covers ***outpatient surgery*** (other than in a physician's office) and related services as follows:

- Anesthesiologist/anesthetist
- Equipment related to the surgery

- Facility
- Supplies related to the surgery
- Surgeon

Physical Therapy (Prior Authorization Required)

See Short-Term Rehabilitation for combined maximum.

- Includes X-rays and other services provided by an in-network licensed therapist or doctor of oriental medicine.

Prescription Drugs (other than those dispensed under the Prescription Drug Plan)

The Plan will cover prescription drugs as follows:

- Enteral nutrition for diagnosis of dysphagia (difficulty swallowing), as the sole source of nutrition, or in cases of RH factor, or in cases of Phenylketonuria (PKU) genetic disorder
- Intravenous medications
- Medication that is dispensed and/or administered by a licensed facility or provider such as a ***hospital***, home health care agency, or physician's office, and the charges are included in the facility or ***provider*** bill

Preventive Care

The Plan covers certain services under the preventive care benefit as outlined below.

Routine Physical Exam

Routine physical exam benefit: One routine physical exam is allowed each calendar year, irrespective of the date of the previous routine physical exam, and not more frequently than one per calendar year.

Allowable exams include sports physicals.

A covered member is eligible for annual routine physical exam even if the participant has any type of chronic ***illness*** or condition such as high blood pressure, diabetes, etc.

It is solely up to the ***provider*** as to whether the service is coded as preventive or diagnostic. Neither Sandia nor CIGNA HealthCare can direct the ***provider*** to bill a service in any particular way. This issue as to how it is billed is between you and your ***provide****r*.

Well-Baby Care (0-2 years) at 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 18 months, and 24 months

- Routine physical exam (including height and weight):
    - Hearing exam, as needed
    - Thyroid screen, as needed
    - Serum lead screen, as needed
    - Sickle cell anemia screen, as needed
    - Hemoglobin/Hematocrit, between 9 and 12 months
    - Phenylketonuria (PKU)

Well-Child Care (3-10 years)

Routine annual physical exam (including height and weight)

- Hearing exam (as needed)

Well-Adolescent Care (11-18 years)

- Routine annual physical exam (including height, weight, and blood pressure)
    - Chlamydia screen, annually as needed
    - Rubella screen, limited to one per lifetime
    - Sexually transmitted diseases screening, as needed

Well-Adult Care (19 years of age and older)

- Routine annual physical exam (including height, weight, and blood pressure)

- Chlamydia screen, annually as needed
- Rubella screen, limited to one per lifetime
- Sexually transmitted diseases screening, as needed

Immunizations/Flu Shot Services

The Plan will pay 100 percent of the in-network eligible expense related to immunizations, including flu shots, the pneumococcal vaccine, and immunizations needed for personal travel. Immunizations for Sandia business-related travel are required to be done at Sandia's onsite clinic; however, if Sandia's onsite clinic refers the employee to get immunizations off-site, the covered member will be reimbursed at 100 percent of the eligible expense, regardless of whether the ***covered member*** obtains the immunizations in- or out-of-network.

Note: If you are unable to obtain the type of immunization required at the physician's office (e.g., malaria pills), you can go to Concentra at 3800 Commons NE, Albuquerque, NM (505) 822-9480, to receive in-network benefits. If you need to obtain different types of immunizations for personal travel where at least one of these is not available at a physician's office, you may obtain all of your immunizations at Concentra.

Important

*It is solely up to the **provider** as to whether services are coded as preventive or diagnostic. Neither Sandia nor CIGNA HealthCare can direct the **provider** to bill a service in any particular way. The issue as to how it is billed is between you and your **provider**.*

Laboratory Services

For the following laboratory services, for ***covered members*** age 19 and older, the Plan will pay 100 percent of the in-network benefit charge:

- Complete blood count (CBC) with differential - white blood count, red blood count, hemoglobin, hematocrit, platelet, mcv, mchc, rdw, (differential includes neutrophils, lymphocytes, monosite, eosinophil, basophile, absolute neutrophil, absolute lymphocyte, absolute monocyte, absolute eosinophile, absolute basophile, diff type, platelet estimate, red blood cell morphology)
- Complete urinalysis - source, color, appearance, specific gravity, urine PH, protein, urine glucose, urine ketones, urine bilirubin, blood, nitrate, urobilinogen, leukocyte estrase, red blood count, white blood count, squamos epithelial, calcium oxylate
- Complete metabolic profile - sodium, potassium, chloride, co2, anion, glucose, bun, creatinine, calcium, total protein, albumin, globulin, bilirubin total, alkphos, asp, alt
- Diabetes screening - a two-hour postprandial blood sugar and HbA1c

- Thyroid screening - free T4 and TSH
- Lipid panel - triglycerides, total cholesterol, high-density lipoprotein (HDL) and calculated low-density lipoprotein (LDL) cholesterol

As ordered by the physician, ***covered members*** are entitled to one of each of the above category once every calendar year. In order to receive the preventive care benefit, however, the laboratory service must be submitted with a preventive ICD-9 diagnostic code. If it is submitted with a diagnostic code other than the preventive ICD-9 diagnostic code, the service will be reimbursed at the applicable benefit level.

If the physician orders one or more components within one of the above categories but not the complete set, and it is submitted with a preventive code, it will be paid under the preventive benefit.

Important

*It is solely up to the **provider** as to whether the service is coded as preventive or diagnostic. Neither Sandia nor CIGNA HealthCare can direct the **provider** to bill a service in any particular way. The issue as to how it is billed is between you and your **provider**.*

Cancer Screening Services

The Plan will pay 100 percent of the eligible expense for the following services:

Service	Allowed Frequency	Allowable Age
Pap test	Annual	Upon turning 14
Prostrate antigen test	Annual	Upon turning 50
Mammogram*	Baseline Annual	Between 35-39 Upon turning 40
Fecal occult blood test	Annual	Upon turning 50
Sigmoidoscopy**	Once every five years	Upon turning 50
Colonoscopy**	Once every 10 years	Upon turning 50
Barium enema**	Once every five years	Upon turning 50

***** High-risk women with an immediate family history (mother or sister) of breast cancer are eligible for an annual mammogram upon turning 25. The mammogram preventive benefit also includes the computer-aided detection test.

****** You are entitled to the following:

- A sigmoidoscopy once every five years, or
- A colonoscopy once every 10 years, or
- A sigmoidoscopy or colonoscopy before age 50 or more frequently than stated above if you have an immediate family history (mother, father, sister, brother only) of colorectal cancer

Service	Allowed Frequency	Allowable Age
• A barium enema once every five years ***in lieu of*** a colonoscopy or sigmoidoscopy. The preventive benefit also includes the charge by the provider for interpreting the test results. To receive the preventive care benefit, the service must be submitted with a preventive ICD-9 diagnostic code. If it is submitted with a non-preventive ICD-9 diagnostic code, the service will be reimbursed at the applicable copay level.		

Important

*It is solely up to the **provider** as to whether the service is coded as preventive or diagnostic Neither Sandia nor CIGNA HealthCare can direct the **provider** to bill a service in any particular way. The issue as to how it is billed is between you and your **provider**.*

Pregnancy-Related Preventive Care Services

For the following pregnancy-related services, on an as needed basis, the Plan will pay 100 percent of eligible expense:

- Multiple marker screening between weeks 15 and18 for pregnant women age 35 and older
- Serum alpha-fetoprotein between weeks 16 and 18 based on personal risk factors
- Chorionic villus sampling before week 13 or amniocentesis between weeks 15 and 18 in women who are 35 and older or are at risk for passing on certain chromosomal disorders
- Hemoglobiopathy screening if at risk for passing on certain blood disorders
- Screening for gestational diabetes between 24 and 28 weeks gestation
- Screening for group B strep between 35 and 37 weeks gestation
- Initial screening for anemia, rubella, hepatitis B, and sexually transmitted diseases

Other Preventive Care Services

The Plan will pay 100 percent of the eligible expense for bone density testing once every three years upon turning 50 years of age.

Important

*It is solely up to the **provider** as to whether the service is coded as preventive or diagnostic. Neither Sandia nor CIGNA HealthCare can direct the **provider** to bill a service in any particular way. The issue as to how it is billed is between you and your **provider**.*

Prosthetic Devices/Appliances (Prior Authorization Required)

The Plan covers prosthetic devices and appliances that replace a limb or body part or help an impaired limb or body part work. Examples include, but are not limited to:

- Artificial limbs
- Artificial eyes
- Breast prosthesis (including mastectomy bras and lymphedema stockings) following a mastectomy, as required by the Women's Health and Cancer Rights Act of 1998

If more than one prosthetic device meets your functional needs, benefits are available only for the most cost-effective prosthetic device. The device must be ordered or provided by a physician or under a physician's direction.

If the prosthetic device or appliance is lost or stolen, the Plan will not pay for replacement unless the device or appliance is at least five years old. If the device or appliance breaks or is otherwise irreparable, the Plan will pay for a replacement.

Professional Fees for Surgical and Medical Procedures (Prior Authorization Required)

The Plan pays professional fees for surgical procedures and other medical care received from a physician in a ***hospital***, skilled nursing facility, ***inpatient*** rehabilitation facility, ***outpatient surgery facility***.

The Plan will pay the following surgical expenses:

- Only one charge is allowed for the operating room and for anesthesia.
- A surgeon will not be paid as both a co-surgeon and an assistant surgeon.
- Expenses for certified first assistants are allowed if the ***provider*** is licensed in the state where they practice.
- A surgical procedure that is performed and not considered incidental to the primary procedure will be reimbursed at half of the allowable amount. For example, when bilateral surgical procedures are performed by one or two surgeons, the Plan will consider the first procedure at the full allowed amount, and the second at half of the allowed amount of the listed surgical unit value.
- Incidental procedures are those services carried out at the same time as a more complex, primary procedure. The incidental procedure may be a part of the primary procedure and requires little or very little additional time and resources; therefore, they are usually not covered.
- Foot surgery – for a single surgical field/incision or two surgical fields/incisions on the same foot, the Plan will allow the full amount for the procedure commanding the greatest value: half the full amount for the second procedure, half the full

amount for the third procedure, and a quarter of the full amount for each subsequent procedure. Also, if procedure 11721 is billed in conjunction with 10056 and 10057, these will be allowed to be reimbursed separately without bundling when billed with a medical diagnosis.

Reconstructive Procedures (Prior Authorization Required)

This Plan covers certain ***reconstructive procedure***s where a physical impairment exists and the expected outcome is restored or improved physiologic function for an organ or body part.

Important

The fact that a member may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a ***reconstructive procedure****.*

Improving or restoring physiology function means that the organ or body part is made to work better. An example of a ***reconstructive procedure*** is surgery on the inside of the nose so that a person's breathing can be improved or restored. There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part, such as in upper eyelid surgery. At times, this procedure is done to improve vision, which is considered a ***reconstructive procedure***. In other cases, improvement in appearance is the primary intended purpose, which is considered a ***cosmetic procedure***. ***Cosmetic procedures*** are not covered under this Plan.

The following benefits are mandated by the Women's Health Act of 1998. If a ***covered member*** has had a mastectomy, she may elect to have breast reconstruction. Coverage by this plan is provided for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas

Short-Term Rehabilitation (Outpatient) (Prior Authorization Required)

Combined maximum of 60 visits per calendar year including:

- Acupuncture for treatment of chronic musculoskeletal or neurogenic pain
- Chiropractic therapy
- Occupational therapy

- Physical therapy
- Speech therapy

Rehabilitation services must be provided by a licensed therapy ***provider*** and under the direction of a physician. Physical, occupational, and speech therapy are subject to reimbursement with demonstrated improvement as determined by CIGNA HealthCare. Maintenance therapy is not covered.

Speech, occupational, and physical therapies rendered for developmental disorders are covered until the patient is at a maintenance level of care as determined by CIGNA HealthCare.

Manual therapy techniques for lymphatic drainage, including manual traction, etc., are covered when performed by a licensed chiropractor, physical therapist, or physician.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services (Prior Authorization Required)

Facility services for an ***inpatient*** stay in a ***skilled nursing facility*** or ***inpatient*** rehabilitation facility are covered under the Plan. Benefits include:

- Services and supplies received during the ***inpatient*** stay
- Room and board in a semi-private room (a room with two or more beds)

Note: The plan will pay the difference in cost between semi-private room and a private room only if a private room is necessary according to generally accepted medical practice as determined by CIGNA HealthCare.

Benefits are available when skilled nursing and/or ***inpatient*** rehabilitation facility services are needed on a daily basis. Benefits are also available in a ***skilled nursing facility*** or ***inpatient*** rehabilitation facility for treatment of an ***illness*** or ***injury*** that would have otherwise required an ***inpatient*** stay in a ***hospital***.

The intent of skilled nursing is to provide benefits if, as a result of an ***injury*** or ***illness***, you require:

- An intensity of care less than that provided at a general acute ***hospital*** but greater than that available in a home setting or
- A combination of skilled nursing, rehabilitation, and facility services

The Plan does not pay benefits for ***custodial care***, even if ordered by a physician.

Speech Therapy (Prior Authorization Required)

See Short-Term Rehabilitation for combined maximum.

Temporomandibular Joint (TMJ) Syndrome (Prior Authorization Required)

The Plan covers diagnostic and surgical treatment of conditions, including appliances, affecting the ***temporomandibular joint*** when provided by or under the direction of a physician. Coverage includes necessary treatment required as a result of accident, trauma, a ***congenital anomaly***, developmental defect, or pathology.

Travel and Lodging (Prior Authorization Required)

A CIGNA HealthCare case manager will assist the patient and family with travel and lodging arrangements related to transplantation services.

Important

For travel and lodging services to be covered, the patient must be receiving services from CIGNA Lifesource Transplant Network℠.

The Plan covers expenses for travel, lodging, and meals for the patient (provided he or she is not covered by ***Medicare***) and a companion as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant facility for the purposes of an evaluation, the procedure, or necessary post-discharge follow-up
- ***Eligible expenses*** for lodging and meals for the patient (while not a ***hospital inpatient***) and one companion. Benefits are paid at a per diem (per day) rate of up to $50 per day for the patient or up to $100 per day for the patient plus one companion
- If the patient is an enrolled dependent minor (under the age of 18) ***child***, the transportation expenses of two companions will be covered and lodging and meal expenses will be reimbursed at a per diem rate up to $100 per day.

Travel and lodging expenses are only available if the transplant patient lives more than 50 miles from the transplant facility. Examples of travel expenses may include:

- Airfare at coach rate
- Taxi or ground transportation
- Mileage reimbursement at the IRS rate for the most direct route between the patient's home and the transplant facility

A combined overall maximum benefit of $10,000 per covered patient applies for all travel, lodging, and meal expenses reimbursed under this Plan in connection with all transplant procedures and treatments during the entire period that the ***member*** is covered under this Plan.

Note: Please be aware that most of the travel allowance offered as a feature of the transplant program is considered taxable income. The transplant case manager will be able to provide more information.

Urgently Needed Care

The Plan will cover ***urgent care*** as follows:

- From an in-network ***facility,*** within the United States, at the in-network level of benefit for covered charges.
- While on travel, within the United States, you will be covered for services from in-network ***providers*** only.
- While on travel, outside the United States, you will be covered for services at the in-network level of benefit for covered charges.
  - ***Follow-up care*** that results from ***urgently needed care*** while on travel, if you are outside the United States, will be covered at the in-network level of benefit for covered charges.
  - ***Follow-up care*** while on travel, within the United States, will be covered for services from in-network ***provider*** only**.**

Note: You may want to consider getting a list of in-network providers located in the area you will be visiting and carry your member ID card while on travel. Provider listings are available on the web at mycigna.com.

Section 7. Exclusions

What this Cigna In-Network Plan Does Not Cover

Although the CIGNA In-Network Plan provides benefits for a wide range of covered medical services, there are specific conditions or circumstances for which it will not provide benefit payments. In general, this Plan will not pay for any expense that is primarily for the covered member's convenience or comfort or that of the covered member's family, caretaker, physician, or other medical ***provider***.

This Plan does **not** provide for out-of-network coverage except for ***emergency*** and ***urgent care*** that is ***medically necessary***.

General Medical Plan Exclusions

You should be aware of exclusions that include but are not limited to items in the following table.

Exclusions	Examples
Administrative fees, penalties, and limits	Charges that exceed what CIGNA HealthCare determines are eligible expenses Insurance filing fees, attorney fees, physician charges for information released to CIGNA HealthCare, and other service charges and finance or interest charges Amount you pay for failure to contact the CIGNA HealthCare claims administrator for prior authorization or pre-certification, including unauthorized care Employee Assistance Program services when you do not obtain pre-certification from CIGNA Behavioral Health Charges incurred for services rendered that are not within the scope of a provider's licensure Charges for missed appointments
Ambulance Services	Nonemergency ambulance services are not covered.

Behavioral Health Services	Family therapy, including marriage counseling and bereavement counseling. Family therapy, marriage counseling, and bereavement counseling are covered for employees and their dependents only through the EAP (call CIGNA Behavioral Health at 1-800-244-6224). Conduct disturbances unless related to a coexisting condition or diagnosis otherwise covered Educational, vocational, and/or recreational services as outpatient procedures Biofeedback for treatment of diagnosed medical conditions Treatment for learning disabilities and pervasive developmental disorders other than diagnostic evaluation Treatment for insomnia, other sleep disorders, dementia, neurological disorders (including autism) other than diagnostic evaluation Treatment that is determined by CIGNA Behavioral Health to be for the covered member's personal growth or enrichment Court-ordered placements when such orders are inconsistent with the recommendations for treatment of CIGNA Behavioral Health participating provider for mental health, the primary care physician, or CIGNA Behavioral Health Services to treat conditions that are identified by the most current edition of the *Diagnostic and Statistical Manual of Mental Disorders* as not being attributable to a mental disorder Sex transformations Any services or supplies that are not medically necessary or appropriate Custodial care Pastoral counseling Developmental care Treatment for caffeine or tobacco addiction (with the exception of hypnotherapy and biofeedback for tobacco addiction), withdrawal, or dependence Aversion therapies Treatment for codependency Non-abstinence-based or nutritionally based treatment for substance abuse Services, supplies, or treatments that are covered for benefits under the medical part of this Plan Treatment or consultations provided via phone, except for transition of care or interim care for no more than a six-month maximum transition period Services, treatments, or supplies provided as a result of any Worker's Compensation law or similar legislation, or obtained through, or required by, any government agency or program, whether federal, state, or subdivision of, or caused by the conduct or omission of a third party for which the covered member has a claim for damages or relief, unless the covered member provides CIGNA Behavioral Health with a lien against such claim for damages or relief in a form and manner satisfactory to CIGNA Behavioral

	Health Conditions resulting from insurrection, except for injuries inflicted on an innocent bystander who is a covered member under this Plan Nonorganic erectile dysfunction (psychosexual dysfunction) Treatment for conduct and impulse control disorders, personality disorders, paraphilias (unusual sexual urges) and other mental illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as determined by CIGNA Behavioral Health Services or supplies that • Are considered experimental or investigational (such as drugs, devices, treatments, or procedures) • Result from or relate to the application of such experimental or investigational drugs, devices, treatments, or procedures, or result from or relate to the application of such experimental or investigational drugs, devices, treatments, or procedures • Are programs of recreational and outdoors experience, including wilderness programs, boot-camp-type programs, and work-camp-type programs Services or supplies that are primarily for the covered member's education, training, or development of skills needed to cope with an injury or illness
Congenital Health Disease	Services, other than those listed below, are excluded from coverage unless determined by CIGNA HealthCare to be proven procedures for congenital heart disease. • Outpatient diagnostic testing • Evaluation • Surgical interventions • Interventional cardiac catheterizations (insertion of a tubular device in the heart) • Fetal echocardiograms (examination, measurement, and diagnosis of the heart using ultrasound technology • Approved fetal interventions
Cosmetic Surgery	See Physical Appearance in this section
Dental Procedures	Dental procedures are not covered under this Plan except for injuries to sound, natural teeth, the jaw bone, or surrounding tissue or birth defects. Treatment must be initiated within 12 months of injury. Jaw joint disorders (TMJ) and orthognathic surgery are covered only if medically necessary. Dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not covered.

Drugs	Outpatient prescription drugs are covered under the Prescription Drug Program, except drugs dispensed, administered, and billed through the provider or facility that is approved by CIGNA HealthCare for coverage and all intravenously administered medications.
Employee Assistance Program (EAP)	EAP benefits are not available to retirees, survivors, long-term disability terminees, VSIP recipients or dependents of those individuals.
Equipment	Exercise equipment (e.g., exercycles, weights, etc.) Hearing aids for hearing loss (see detail in Section 6, Coverages and Limitations Braces prescribed to prevent injuries while you are participating in athletic activities Household items, including but not limited to: • air cleaners and/or humidifiers • bathing apparatus • scales or calorie counters • blood pressure kits • water beds Personal items, including but not limited to: • support hose, except medically necessary surgical or compression stockings • foam cushions • pajamas Items payable under the Prescription Drug Program Equipment rental fees above the purchase price, with the exception of oxygen equipment
Experimental or investigative treatment	Experimental or investigative drugs, devices, medical treatments or procedures, and any related services
Hospital fees	Expenses incurred in any federal hospital, unless the covered member is legally obligated to pay Hospital room and board charges in excess of the semi-private room rate unless medically necessary and approved by the CIGNA HealthCare claims administrator In-hospital personal charges (e.g., telephone, barber, TV service, toothbrushes, slippers)
Hypnotherapy	Hypnotherapy is generally not a covered health service, but the Plan will allow up to five visits per lifetime for smoking cessation.
Infertility, Reproductive, and Family Planning	**Note:** Infertility treatment is **not** a covered benefit under this Plan. Items that are not covered include, but not limited to:

	• Purchase of eggs • Services related to or provided to anonymous donors • Services provided by a doula (labor aide) • Storing and preserving sperm • Donor expenses related to donating eggs/sperm, including prescription drugs (extracting eggs from covered member for donor is covered) • Expenses incurred by surrogate mothers • Artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes • Over-the-counter medications for birth control/prevention • Parenting, prenatal, or birthing classes
Miscellaneous	Eye exams or eye refractions, **except** for non-refractive care due to illness or injury to the eye Eyeglasses or contact lenses prescribed, **except** when required due to loss of a natural lens. Contact lenses are not considered a prosthetic device Modifications to vehicles and houses for wheelchair access Health club memberships or spa treatments Treatment or services: • incurred when the patient was not covered under this Plan even if the medical condition being treated began before the date your coverage under the Plan ends • for illness or injury resulting from the covered member's intentional acts of aggression, including armed aggression, except for injuries inflicted on an innocent bystander (e.g., you did not start the act of aggression) • for job-incurred injury or illness for which payments are payable under any Workers' Compensation Act, Occupational Disease Law, or similar law • while on active military duty • for treatment of military-service-related disabilities when you are legally entitled to other coverage and facilities are reasonably accessible • that are reimbursable through any public program other than Medicare or through no-fault automobile insurance. Charges in connection with surgical procedures for sex changes Charges for blood or blood plasma that is replaced by or for the patient Conditions resulting from insurrection, except for injuries inflicted on an innocent bystander who is a covered member under this Plan. Christian Science practitioners and facilities Food of any kind unless it is the only source of nutrition, there is a diagnosis

	of dysphagia (difficulty swallowing), or in cases of RH factor or PKU. Enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk Foods to control weight, treat obesity (including liquid diets), lower cholesterol, or control diabetes Oral vitamins and minerals (with the exception of oral calcium supplements for clinically documented hypoparathyroidism and Niferex and certain prescription vitamins) Herbs and over-the-counter medications, except as specifically allowed under the Plan Charges prohibited by federal anti-kickback or self-referral statutes Chelation therapy, except to treat heavy metal poisoning Diagnostic tests that are: • Delivered in other than a physician's office or health care facility • Self-administered home diagnostic tests, including but not limited to HIV and pregnancy test Domiciliary care Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for ten seconds or longer). Appliances for snoring are always excluded. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when: ▪ Required solely for purposes of career, education, camp, employment, insurance, marriage, or adoption, or as a result of incarceration ▪ Conducted for purposes of medical research ▪ Related to judicial or administrative proceedings or orders ▪ Required to obtain or maintain a license or any type Private duty nursing received on an ***inpatient*** basis Respite care Rest cures Storage of blood, umbilical cord, or other material for use in a ***covered health service***, except, if needed for imminent surgery
Not a covered health service and/or not medically necessary	Treatments or services determined not to be medically necessary or appropriate and, therefore, determined not to be a covered health service by CIGNA HealthCare or CIGNA Behavioral Health
Old Claims	Claims received 12 months after date charges were incurred
Physical Appearance	Breast reduction/augmentation except after breast cancer and/or medically necessary Any loss, expense or charge that results from cosmetic or reconstructive

	surgery (except after breast cancer) but not including: o repair of defects that result from surgery for which the covered member was paid benefits under the policy o reconstruction (not cosmetic) repair of a congenital defect that materially corrects a bodily malfunction. **Note:** For the purpose of this exclusion, poor self-image or emotional or psychological distress do not constitute a bodily malfunction. Liposuction Pharmacological regimes Nutritional procedures or treatments Tattoo or scar removal or revision procedures, such as salabrasion, chemo-surgery and other skin abrasion procedures Replacement of an existing intact breast implant unless there is documented evidence of silicon leakage Physical conditioning programs, such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation Weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity Wigs regardless of the reasons for hair loss Treatments for hair loss
Providers	Services: • Performed by a provider who is a family member by birth or marriage, including your spouse, brother, sister, parent, or child • A provider may perform on himself or herself • Performed by a provider with your same legal residence • Provided at a diagnostic facility (hospital or otherwise) without a written order from a provider • Ordered by a provider affiliated with a diagnostic facility (hospital or otherwise) when that provider is not actively involved in your medical care prior to ordering the service or after the service is received This exclusion does not apply to mammography testing.
Services, supplies, therapy, or treatments	Charges that are: • custodial in nature • otherwise free of charge to the covered member • furnished under an alternative medical plan provided by Sandia • for aromatherapy or rolfing (holistic tissue massage) • for occupational and speech therapies that can be accessed through government-related programs (e.g., school system, state programs) • for developmental care after a maintenance level of care has been

	reached • for maintenance care • for massage therapy, unless performed by a licensed chiropractor, physical therapist, or physician as a manual therapy technique for lymphatic drainage • for educational therapy when not medically necessary • for educational testing • for smoking-cessation programs, except for biofeedback and hypnotherapy limited to a maximum of five visits each per lifetime • for surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia, and astigmatism, including but not limited to procedures such as laser and other refractive eye surgery and radial keratotomy
Surgical and non-surgical treatment for obesity	Surgical operations for the correction of morbid obesity determined by CIGNA HealthCare not to be medically necessary or appropriate to preserve the life or health of the covered member Treatment for over-the-counter appetite control, food addictions, or eating disorders that are not documented cases of bulimia or anorexia meeting standard diagnostic criteria as determined by CIGNA HealthCare
Transplants	Organ and tissue transplants, including multiple transplants except as identified under Section 6, Coverages and Limitations, and determined by CIGNA HealthCare not to be a proven procedure for the involved diagnosis and not consistent with the diagnosis of the condition Mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available) Donor costs for organ or tissue transplantation to another person unless the recipient is a covered member under this Plan
Transportation	Nonemergency ambulance services are **not** covered. Transportation, except ambulances and air ambulance, to the nearest hospital except when medically necessary and for the movement between hospitals when medically necessary to a facility in the area of the member's permanent residence or for approved transplant services
Travel	Travel and transportation expenses, even if ordered by a physician, except as identified in Section 6, Coverages and Limitations

Section 8. Accessing Care

This section describes how to access care under this Plan. Certain procedures require review, such as prior authorization to receive benefits. Information on supporting services that are available to you as a ***member*** in this Plan is included in this section.

CIGNA In-Network Plan

The CIGNA In-Network Plan provides you access to network physicians, facilities, and suppliers who are contracted with CIGNA HealthCare, the ***claims administrator***. CIGNA HealthCare negotiates discounts with their ***participating providers*** for ***members***. This results in lower out-of-pocket costs to you. Under this Plan, all services and supplies must be acquired from the contracted ***providers*** and be ***medically necessary*** to be considered a covered benefit under this Plan. Please refer to Section 6, Coverage and Limitations, for coverage details. For the most up-to-date in-network ***provider*** listings in your area, contact CIGNA HealthCare.

The advantages of using the CIGNA In-Network Plan include:

- No annual ***deductibles***
- Lower out-of-pocket costs
- ***Copays*** only
- Generally, no claims to file

Out-of-Network Option

The Plan does **not** have an out-of-network option. You are responsible for all expenses for out-of-network services.

Out-of-Area Coverage

The Plan does **not** have provisions for ***out-of-area coverage***.

Prior Authorization

The purpose of prior authorization is that it:

- Allows you to know in advance whether a procedure, treatment, or service will be covered under your plan
- Helps ensure that you receive the appropriate level of care in the appropriate setting

- Enables CIGNA HealthCare to identify situations that may allow you to receive additional attention (e.g., referrals to disease or case management programs) based on the type of service requested.

To receive maximum benefits under this Plan, the ***provider*** must obtain prior authorization for certain benefits. It is the ***covered member's*** responsibility to check with the ***provider*** to ensure that this requirement is met. If prior authorization is not obtained when required, and this Plan is your primary coverage, a $300 penalty will apply. This means that the first $300 of the claim will not be paid.

If your primary care physician and CIGNA HealthCare do not agree in advance with the need for services or treatment, the ***covered member*** can appeal the decision by asking that CIGNA HealthCare review the situation. Appeal procedures are listed in Section 11, Claims and Appeals. Regardless of the decision and/or recommendation of CIGNA HealthCare, or what the plan will pay, it is always up to the ***covered member*** and the doctor to decide what, if any, care he or she receives. CIGNA HealthCare does not provide medical advice.

For prior authorization, call CIGNA HealthCare at 1-800-244-6224.

The following services require prior authorization to receive the highest level of benefits unless you have another plan as your primary coverage.

- ***Hospital*** stay:
    - ***Inpatient***—seven days advance notice
    - ***Emergency*** hospitalization—call within two working days after admission
- Surgical procedures:
    - ***Inpatient*** or ***outpatient***—seven days advance notice
    - ***Emergency*** surgery—call within two working days of procedure
- ***Outpatient*** surgical procedures:
    - Back/spine procedures
    - Carpal tunnel release
    - Cochlear implants
    - Endometrial ablations
    - Hysterectomy
    - Knee arthroscopy
    - Orthognathic procedures
    - Pelvic laparoscopy
    - Tonsillectomy with or without adenoidectomy

    - Tympanostomy tube insertion
    - UPP (uvulopalatopharyngoplant) or laparoscope-aided UPP
- ***Durable medical equipment*** and supplies
- Elective MRI, CT, and PET scans
- Skilled nursing
- Home health care
- Home infusion therapy
- ***Hospice***
- Hysterectomy
- Injectable medications
- Insulin pumps
- Therapies
- Transplants
- Varicose vein treatment
- Employee Assistance Program (except for initial visit)
- Behavioral health—***inpatient*** or ***outpatient*** care (except for initial visit)

Important

*The first $300 of covered charges will not be reimbursed if you or a family **member** do not obtain required prior authorization from CIGNA HealthCare, or fail to notify CIGNA HealthCare within the required time frame for hospitalization, surgeries, and other procedures listed above as requiring prior authorization. An exception to this requirement would be for a **covered member** who has primary health care coverage under another non-Sandia health care plan.*

Predetermination of Benefits

This Plan covers a wide range of medical care treatments and procedures. However, medical treatments that are ***investigational***, ***experimental***, or not proven to be medically effective are not covered under this Plan. Contact CIGNA HealthCare before incurring charges that may not be covered under this Plan.

In addition, some services may not be covered under certain circumstances (see Section 7, Exclusions) and may be limited in scope, such as speech therapy, occupational therapy, physical therapy, temporomandibular joint (***TMJ***) syndrome, infertility, and procedures that may have a cosmetic effect. Predetermination of benefits is recommended to help you determine your out-of-pocket expense. Also, some benefits require prior au-

thorization as described above. Therefore, it is important that you call CIGNA HealthCare at 1-800-244-6224 for information on covered services.

Case Management

The Case Management Program assists patients requiring extensive hospitalization or patients who have complicated discharge planning needs. The program identifies those patients so that coordination of services and alternative (cost-effective) care arrangements can be made. Referral to case management screening takes place when:

- Two or more admissions within three months for the same or a related medical condition
- Two or more ***emergency*** or ***urgent care*** visits within three months for the same or related medical condition
- A ***hospital*** stay of more than 10 days
- Over $25,000 in claims year-to-date for the same or related condition

Case management also takes place for the following medical conditions:

- Cancer
- Cerebrovascular accident (CVA)
- Chronic respiratory disease
- Congenital heart disease
- Diabetes
- Immune system deficiencies
- Infectious disease
- Ischemic heart disease
- Neonatal complications
- Neurodegenerative disorders, including multiple sclerosis, muscular dystrophy, amyotrophic lateral sclerosis
- Organ transplant
- High-risks pregnancies
- Spinal cord injuries
- Trauma

Special care arrangements, as determined by the case manager, are coordinated with the physician.

Case management is a voluntary, confidential, and private process, and may involve some or all of the following activities:

- Establishing goals and care plan with the physician, ***covered member***, and/or family that may include onsite visits
- Assessing ongoing treatment at a ***hospital***, rehabilitation center, nursing home, ***hospice***, or the ***covered member's*** home
- Investigating alternative facilities and services
- Establishing home health care treatment, if appropriate
- Planning for discharge

The intent of case management is to ensure that ***medically necessary*** and appropriate services are provided to the ***covered member***. The evaluation process used in case management may reduce medically unnecessary, inappropriate, and/or harmful services, and manage costs in some cases. For more information, call CIGNA HealthCare at 1-800-244-6224.

Disease Management (CIGNA HealthCare)

The CIGNA HealthCare disease management program is known as the Well Aware Program for Better Health®. This disease management program is a voluntary program that helps ***covered members*** manage chronic conditions such as:

- Asthma—aims to help ***members*** prevent or lessen the severity of attacks in a variety of way
- Diabetes—helps ***members*** understand their condition and how it affects their overall health
- Heart disease—helps ***members*** with coronary artery disease or congestive heart failure stay attuned to their day-to-day health and become better prepared to discuss their concerns with their physician
- Low back pain—helps ***members*** lessen their symptoms and manage their condition
- Chronic-obstructive pulmonary disease—helps ***members*** improve their breathing and manage their symptoms

The ***covered member*** will receive personalized guidance and support from an experienced registered nurse. The ***member*** will receive information about their condition as well as reminders about important screenings and exams.

Disease Management Clinic (Sandia)

The Disease Management Clinic (DMC) is a worksite specialty clinic designed to provide an exceptional level of health care for diabetes, cholesterol, and blood pressure disorders. With a unified commitment to the best care practices available, the DMC is Sandia's interface to workplace health care and health plan services. The DMC provides access to onsite screenings, health care exams, preventative health education, care management and behavioral, fitness and nutrition services, periodic laboratory testing, immunizations, and podiatry services for diabetic foot care. Sandia's multidisciplinary team of health professionals consists of internal medicine physicians, certified diabetes educators, dieticians, health educators, and exercise specialists.

Employees who are at increased risk for or have a history of elevated blood pressure, cholesterol, or diabetes and interested in becoming involved in Sandia's DMC may call 844-HBES (4237) to schedule an appointment.

Behavioral Health Program

The Behavioral Health Program and the network of ***behavioral health*** care ***specialists*** are managed by CIGNA Behavioral Health. Coverage under this Plan provides for the CIGNA Behavioral Health benefit at the in-network level of coverage. Contact CIGNA Behavioral Health at 1-800-244-6224 or go online at cignabehavioral.com to determine whether your ***specialist*** is an in-network ***provider***.

You must have prior authorization from CIGNA Behavioral Health to access ***behavioral health*** services after the first visit. Prior authorization is not required for your first appointment. If you have scheduled a second visit, make sure your ***behavioral health*** care practitioner has called CIGNA Behavioral Health for prior authorization of treatment before the second visit. You will incur a $300 penalty if prior authorization to seek services from the billing ***provider*** is not on file.

Under this Plan, you must see a contracted network ***provider*** for ***inpatient*** or ***outpatient behavioral health*** care services. Prior authorization for services (except for initial visit) is required from the CIGNA Behavioral Health.

For assistance with the selection of an in-network ***behavioral health specialist***, contact CIGNA Behavioral Health at 1-800-244-6224 or go online at cignabehavioral.com

Out-of-Network Behavioral Health Option

The out-of-network option under this Plan is **not** available. You are responsible for all expenses for out-of-network services.

Maximum Available Behavioral Health Benefit

Medical necessity review and prior authorization of the ***behavioral health*** treatment is required in order to qualify for the maximum available benefits under this Plan. The medical necessity review determines if the treatment plan will meet your needs and whether treatment is ***medically necessary*** under the terms of this Plan. The review is conducted by CIGNA Behavioral Health and the ***behavioral health*** care ***specialist*** you have selected.

You have an ***inpatient*** confinement limit of 45 days per calendar year for ***inpatient*** mental health and 15 days per calendar year for ***inpatient substance abuse***.

You have an ***outpatient*** maximum of 30 visits per calendar year for mental health and an ***outpatient*** maximum of 30 visits per calendar year for ***substance abuse***.

Emergency Treatment for Behavioral Health

In the case of ***inpatient*** and/or ***emergency*** services, the ***behavioral health*** care practitioner, the ***emergency*** service, a friend, or family member must notify CIGNA HealthCare within two working days of admission or as soon as reasonably possible. If ***inpatient*** or ***emergency*** services occur after business hours, or on a holiday or weekend, voice message is available, and a call will be returned the next business day.

If the ***hospital*** is not in the network, in-network benefits will be paid until the patient is stabilized. Once stabilized, the patient must move to a network ***hospital*** to continue coverage under the in-network level of benefit.

Employee Assistance Program

This Plan provides counseling services of an ***Employee Assistance Program (EAP) provider*** to ***covered members***. ***EAP*** services provide assessment, referral, and follow-up to covered members experiencing impairment from personal concerns, including health, marital, family, financial, ***substance abuse***, legal, emotional, stress.

Accessing EAP Services

You are offered two access points to receive ***EAP*** counseling: offsite and onsite.

- Offsite. Contact an in-network ***EAP*** affiliate identified in your CIGNA provider directory. For help identifying an in-network ***EAP counselor***, contact CIGNA HealthCare at 1-800-244-6224 or visit cignabehavoiral.com. ***Providers*** are available in the following specialties:
    - Adoption issues
    - Alcohol/***substance abuse***

- Anxiety issues
- Child/adolescent issues
- Cultural issues
- Depression
- Eating disorders
- Faith-based counseling
- Gender/sexuality
- Grief and loss
- Health issues
- Martial/couples counseling
- Medication management

In general, any master's-level clinician may provide ***EAP*** services. Click on any counselor's name to determine whether his/her clinical practice includes ***EAP***.

- Onsite. Contact your Sandia ***EAP*** office. The Sandia ***EAP*** is administered by the Sandia Medical Clinic and is not a contracted ***provider*** under this Plan. For Sandia ***EAP*** services, call:
  - In Albuquerque, NM (505) 845-8085
  - In Livermore, CA (925) 294-2200

  The Sandia ***EAP*** provides information regarding education and training programs at the worksite that focus on mental health issues, such as ***substance abuse***, family and marital concerns, stress, and health lifestyles development. The Sandia ***EAP*** also assists employees and managers in resolving work-related issues that might be affecting the employee's productivity.

EAP Benefits and Prior Authorization Requirements

Your ***EAP*** benefit allows up to eight visits, annually, to an offsite, in-network ***EAP provider*** at no cost to you and your ***covered members***. It is important to note that except for the initial visit, the in-network ***EAP*** affiliate you select is responsible for calling CIGNA HealthCare to receive authorization for additional visits beyond the initial assessment visit.

Confidentiality

EAP counseling services are confidential within the limitations imposed by state and federal law and regulations. When a ***covered member*** visits an ***EAP counselor*** for the first time, confidentiality is described in more detail.

Nonemergency or Nonurgent Care When Away from Home

If you are not experiencing an ***emergency*** or ***urgent care*** situation, call CIGNA HealthCare at 1-800-244-6224 to obtain information on in-network ***providers*** located in the area you will be visiting.

If you access an out-of-network ***provider*** or facility for ***nonemergency*** or ***nonurgent*** care, even if there are no in-network ***providers***, your claim will be denied.

CIGNA HealthCare has contracted with providers nationwide. It is advisable that you do a provider search at www.mycigna.com to locate providers located in the area you will be visiting. Consider taking your medical care ID card while you are on travel. Your ID card is useful for providers in determining your plan coverage. The back of your ID card has the toll free number that is available to you for assistance concerning your medical plan coverage.

Provider Networks

Network availability depends on the ability of CIGNA HealthCare to contract with ***providers***. CIGNA HealthCare has contracted with ***providers*** across the country.

Sandia strives, through CIGNA HealthCare, to make available to the ***covered member*** quality health care service by way of the credentialing process. Even though Sandia strives to provide quality medical services, neither Sandia nor its Plans can guarantee quality of care. Employees always have the choice of what services they receive and who provides their health care regardless of what the Plan covers or pays.

The network ***provider***, specialty care physicians, ***hospitals***, and other health care ***providers***/facilities participating in the network are contracted by CIGNA HealthCare and CIGNA Behavioral Health.

In some cases, CIGNA HealthCare has established direct contract with individual ***providers***. The ***participating providers*** work with CIGNA HealthCare to organize an effective and efficient health care delivery system. Outside the greater Albuquerque area, CIGNA HealthCare has contracted with ***providers*** offering in-network care.

> **Note:** Your physician may contact CIGNA HealthCare to request membership in any of these networks.

The most current directory of in-network ***providers*** can be found on mycigna.com. Register first to access this valuable tool.

CIGNA Lifesource Transplant Network

CIGNA Lifesource is a network of participating organ and tissue transplant centers that have been evaluated for favorable rates of patient outcomes, as well as waiting periods, housing arrangements, and patient friendly environments. Covered members in the CIGNA Lifesource are managed by the Comprehensive Transplant Case Management Unit. This unit consists of registered nurses with clinical experience in transplant, hematology/oncology, home health care, dialysis, critical care, and/or community care. They are specially trained to manage complex transplant cases. In some instances, a travel allowance is offered as a feature of the program. Most of these expenses are usually considered taxable income.

Prescription Drug Program

As a ***covered member*** in CIGNA In-Network Plan, you are provided a two-tiered, closed ***formulary***, prescription drug benefit at retail stores and an in-network benefit for mail-order prescription drugs.

For a listing of the CIGNA HealthCare Preferred Drug List, visit cigna.com or call the number on your CIGNA HealthCare ID card.

Prescription drugs are covered at the ***copay*** amount as shown in the following table. These amounts are subject to change and are communicated during the ***open enrollment*** period Sandia holds each fall:

Tier	In-Network Benefit Only	
	Retail	
1	Generic	$10 copay (up to 30-day supply)
2	Brand Name (preferred)	$30 copay (up to 30-day supply)
3	Brand Name (nonpreferred)	Not Available
Tier	**Mail Order**	
1	Generic	$20 (up to 90-day supply)
2	Brand Name (preferred)	$60 copay (up to 90-day supply)
3	Brand Name (nonpreferred)	Not Available

To get your prescription filled:

- take your prescription to any CIGNA HealthCare participating pharmacy
- present your CIGNA HealthCare ID card
- pay your ***copay*** amount

Participating pharmacies include major chains as well as local drug stores. Check your directory at cigna.com or call the number on your ID card.

Savings Through Mail Order

You may want to take advantage of the savings available through a mail-order prescription drug program. For example, you may be able to order a three-month supply of generic medication for $20 instead of paying $30 at a retail store for three separate prescriptions. To get a mail-order prescription, ask your physician to give you one 30-day prescription and a separate prescription for the year to get your prescription through mail order. You may get a mail-order prescription form by calling Sandia HBES at (505) 844-4237 or at mycigna.com (after registering for access).

CIGNA HealthCare ***members*** who register for access to mycigna.com can order refills and access their prescription order history online.

The CIGNA mail-order program is through Tel-Drug at 1-800-835-3784.

Generic to Brand (Preferred) to Brand (Nonpreferred)

Every prescription drug has two names: the trademark, or brand name; and the chemical, or generic name. By law, both brand-name and generic drugs must meet the same standards for safety, purity, strength, and quality.

Many drugs are available in generic form. Generic drugs offer substantial cost savings over brand names. Unless your doctor has specified that the prescription be dispensed as written, your prescription will be filled with the least expensive acceptable generic equivalent when available and permissible by law. If you receive a generic medication in place of the brand-name medication, and you want the brand-name medication, you will need to obtain a new prescription stating “no substitution” or “dispensed as written.”

Alternatively, some brand-name drugs have other less expensive brand-name drugs that are acceptable therapeutic equivalents. When these are available, the least expensive acceptable brand-name drug will be substituted for a more expensive brand-name drug when permissible by law and when you and your doctor agree with the substitution.

If for some reason you are unable to substitute any of the preferred brand-name drugs for a nonpreferred brand-name drug, have your physician complete a Medication Prior Authorization Form and fax it to 1-800-390-9745. The standard response time for prescription drug coverage requests is two to four business days. If your request is urgent, call Pharmacy Services at 1-800-244-6224 to expedite your request.

CIGNA HealthCare will review your request and decide whether you will be able to receive the nonpreferred brand-name drug for the preferred brand-name ***coinsurance***/ ***copay*** amount.

Provider Directories

The provider directories list ***providers*** and auxiliary services available in-network. You can select your physician from family care physicians, internists, pediatricians, and other specialists who have contracted to participate in the CIGNA Open Access Plus Network.

Specialty care and ***hospital*** services generally are provided by the ***hospital*** with which the physicians or specialists you select are affiliated.

Provider directories will be furnished by CIGNA HealthCare or may be obtained online as described below. Directories are current as of the date they are printed. The ***provider*** networks change often. For the most current information, contact CIGNA HealthCare at 1-800-244-6224 or, without registering, access the web information at cigna.com. Select the Open Access Plus option as the network type.

Online Directories

The most up-to-date directories are available online. The CIGNA HealthCare ***provider*** directory listings on the web are updated every two weeks. Register at mycigna.com to access your personalized medical care information. The system will know in which plan you are enrolled.

When You Schedule Appointments

When you call the ***provider's*** office to make an appointment, identify yourself as a ***member*** of the CIGNA In-Network Plan (Open Access Plus Network). When you check in for your appointment, use your Plan ID card to identify your plan coverage and to facilitate the processing of your claim.

Note: Failure to present the ***covered member***'s ID card may result in incorrect billing and claim payment delay.

Canceling Your Appointment

If you cannot keep your appointment, please be courteous to other ***members*** and to your ***provider*** by calling to cancel your appointment. The time you leave open is needed by someone else to receive medical care. Any charge for missed appointments will not be covered by this Plan.

Transferring Your Medical Records

If you want your previous medical records transferred to your physician's office, ask the office receptionist for instructions. You may also ask your former physician to transfer your records.

When You Change Your Address

When you move, please change your address in the Sandia database. Active employees may change their address through Sandia's website or their center secretary. Retirees should contact the retirement coordinator through NM HBES (505) 844-4237 or CA Benefits (925) 294-2254

Note: You **must** disenroll or enroll your dependents in this Plan within 31 calendar days of the effective date of change in ineligibility or eligibility for coverage under this Plan.

Section 9. Resources to Help You Stay Healthy

This section provides information on resources that are available to you as a ***member*** of the CIGNA In-Network Plan.

CIGNA HealthCare brings a comprehensive medical program to cover your and your family's needs. It is CIGNA HealthCare's goal to provide ***covered members*** with information to help them manage medical conditions and resources and tools to help them become educated health care consumers.

Note: To get your personalized information, go online at mycigna.com and select "Register Now!" You will be asked for your date of birth, zip code, and ***member*** ID.

www.mycigna.com

As a ***member*** of the CIGNA HealthCare Plan, you may register online at mycigna.com to access the following information and tools.

- Locate a network ***provider*****.** Find the most up-to-date information on contracted ***providers***, ***hospitals***, and facilities closest to home and work. The website is updated every two weeks. Select the Open Access Plus option as the network type.
- 24-hour Health Information Line[SM]. Get assistance from a registered nurse 24-hours a day, seven days a week, who can answer your health questions, provide home care suggestions, help you choose the most appropriate care, and help you locate a contracted ***provider*** if you are out of your ***service area***.

  The Health Information Line[SM] also provides access to hundreds of health topics through a library of audio tapes. The programs are updated regularly and are based on current medical research and treatments. Listen to as many programs as you like, 24-hours a day, seven days a week, by calling 1-800-564-9286.
- Well-Aware Disease Management Program[SM]. Get help managing your chronic conditions. Through the Well-Aware program, you can receive support with chronic conditions such as asthma, diabetes, health disease, low-back pain, and chronic obstructive pulmonary disease. Each program is personalized and offers a wide selection of tools. For more information, call 1-877-888-3091.
- Health Babies Program®. Get free educational materials about pregnancy and babies and round-the-clock access to a toll-free information line staffed by experienced registered nurses. For high-risk pregnancies, support is available from a registered nurse case manager to help with special care needs. Call CIGNA at 1-800-244-6224, or log onto mycigna.com for more information.

The following personalized information is available for ***covered members*** under mycigna.com:

- Plan Benefits. View claim status, view and print an EOB, order ID cards or print a temporary one, locate contracted ***providers***, learn about plan benefits and features, and get answers to frequently asked questions.
- Health Quotient. Fill out a Health Risk assessment questionnaire that provides a health profile and recommendations to help enhance health and well-being.
- Health Record. Enter medications, allergies, surgeries, immunizations, and ***emergency*** contacts into a central, secure location.
- Health Tracker. Input personal health data, such as blood pressure, blood sugar, cholesterol, height, weight, and exercise; the program keeps track of your results so you can share them with your doctor.
- Quality Care Tool. Access information on how ***hospitals*** rank by number of procedures performed, patients' average length of stay, and cost.

Section 10. Coordination of Benefits

This section defines and explains Plan provisions designed to eliminate duplicate payments and to provide the sequence in which coverage will apply (primary and secondary) when a person is covered under two plans.

Note: For ***coordination of benefits*** with ***Medicare***, refer to the Senior Premier PPO Plan ***SPD***.

Policy

All eligible medical coverage under this Plan is subject to coordination with your eligible medical coverage under other health care plans, including ***Medicare***. A covered medical expense is any medical expense that is covered by at least one medical plan during a claim period. An expense due to the ***covered member's*** failure to comply with cost containment requirements (e.g., second surgical opinions, pre-admission testing, pre-admission review of ***hospital confinement***, mandatory ***outpatient surgery***, etc.) will not be considered a covered expense and, therefore, not covered under this Plan.

Important

Beginning January 1 of every year, or if you are a new enrollee, CIGNA HealthCare requires an update on whether any of your covered dependents have other insurance. This information needs to be provided even if your dependents do not have other insurance. If you do not provide this information, CIGNA HealthCare will put a hold on your dependents' claims and request verification in writing from the primary **covered *member*** *for other insurance. You may update your other insurance information by going online at mycigna.com or by calling CIGNA HealthCare at 1-800-244-6224.*

Rules for Determining Which Plan Provides Primary Coverage and Other Details of the Benefit Payment

The rules of the National Association of Insurance Commissioners (NAIC) for the Coordination of Benefits (COB) states that COB:

- Applies only to group plans, **not** to individual insurance
- Does **not** apply when married persons are both ***members*** in Sandia's medical plans
- Follows the birthday rule

Use the following table to determine which plan is responsible for primary coverage and which plan is responsible for secondary coverage.

	IF…	THEN…
1	the other plan (including HMOs) does not have a COB provision,	the plan with no COB provision is primary.
2	both plans have COB provisions,	the plan covering the person as an employee is primary and pays benefits up to the limits of that plan. The plan covering the person as a dependent is secondary and pays the remaining costs to the extent of coverage.
3	both plans have COB provisions and use the birthday rule for dependent children coverage,	the plan covering the parent whose birthday comes first (month and day) in the year is the primary plan and pays benefits first. The plan covering the other parent is secondary and pays the remaining costs to the extent of coverage.
4	both plans have COB but neither uses the birthday rule for dependent children's coverage,	the male-female rule applies. The rule says that the father's group insurance is the primary plan and pays benefits first. The mother's group insurance is secondary and pays the remaining costs to the extent of her coverage.
5	both plans have COB but one parent is covered by the male-female rule and the other by the birthday rule,	the male-female rule applies. The rule says that the father's group insurance is the primary plan and pays benefits first. The mother's group insurance is secondary and pays the remaining costs to the extent of her coverage.
6	a divorce or legal decree establishes financial responsibility for health care for the covered dependent children,	the parent who has the responsibility will be the holder of the primary plan.
7	a divorce decree does not establish financial responsibility for health care coverage of the dependent,	the plan of the parent with custody is the primary plan; the other parent's plan is secondary.
8	a divorce decree does not establish financial responsibility and assigns joint custody,	each parent is primary when the child is living in that parent's home.
9	a divorce decree does not establish financial responsibility, and the parent with custody remarries,	the custodial parent's plan remains primary; the stepparent's plan is secondary; the noncustodial parent's plan is third.
10	payment responsibilities are still undetermined,	the plan that has covered the patient for the longest time is the primary plan.

Coordination of Benefits with Medicare

Sandia interfaces with ***Medicare*** to eliminate duplicate payments and to provide a sequence in which coverage applies. Generally, ***Medicare*** provides primary coverage for those not covered by this Plan by reason of current employment.

Note: For ***coordination of benefits*** with ***Medicare***, refer to the Senior Premier PPO Plan.

If you are eligible for ***Medicare***-primary coverage and are covered under this Plan (under the continuation provisions under ***COBRA***), ***Medicare*** is considered your primary medical coverage.

Covered members who become eligible for ***Medicare***-primary coverage should enroll in ***Medicare*** Parts A and B. Once a ***covered member*** becomes eligible for ***Medicare***-primary coverage, Sandia will pay benefits **only** as secondary payer of benefits, regardless of whether the ***member*** enrolled in ***Medicare*** Parts A and B.

Important

*If a **covered member** who is eligible for **Medicare**-primary coverage is provided primary coverage under this or any other Sandia-sponsored medical plan, the primary **covered member** will be responsible for reimbursing Sandia for any ineligible benefits.*

Behavioral Health Program Coordination with Other Plans

If you are eligible for similar benefits under other non-***Sandia-sponsored medical plans***, your benefits will be coordinated. In addition, if your primary coverage is under another plan and this program provides secondary coverage, you must still follow the rules of this program to receive secondary benefits.

Subrogation and Reimbursement Rights

Subrogation means the Plan's or ***CIGNA HealthCare***'s right to recover any Plan payments made because of an ***illness*** or ***injury*** to you or your covered dependent when the ***illness*** or ***injury*** was caused by a third party's wrongful act or negligence and for which you or your covered dependent have a right of action or later recover said payments from the third party.

If you or your covered dependent requires medical treatment because of a third party's wrongful act or negligence, CIGNA HealthCare will authorize payment of Plan benefits pursuant to the terms of the Plan. As a Plan covered member, you and your dependents acknowledge and agree that:

- The Plan and/or ***CIGNA HealthCare*** is subrogated to any recovery from or right of action against that third party (agree to pay Sandia back if third party pays you).
- You and/or your covered dependent will not take any action that would prejudice the Plan's ***subrogation*** rights (will not impede the Plan's recovery actions).
- You and/or your covered dependent will cooperate in doing what is reasonably necessary to assist in any recovery, including seeking recovery of medical expenses as an element of damages in any action you bring as a result of the activity

resulting in the ***illness*** or ***injury*** (will assist the Plan to directly or indirectly to recover payments).

- You and/or your covered dependent shall reimburse CIGNA HealthCare any money recovered from the third party for any injury or treatment or condition for which CIGNA HealthCare provided benefit.
- CIGNA HealthCare will recover payments only to the extent that Plan benefits paid for treatment were provided as a result of the injury or condition giving rise to the claim.

Sandia will be subrogated only to the extent of Plan benefits paid for that ***illness*** or ***injury***.

Failure to comply with the Plan's ***subrogation*** rules may result in termination of coverage for cause as well as legal action by the Plan to recover benefits paid that would otherwise have been subject to recovery under the Plan's reimbursement/***subrogation*** rights.

Note: If the injured party is a minor dependent, the primary ***member*** must perform the above agreements and/or duties.

Section 11. Claims and Appeals

This section provides an overview of benefits payments, right to recovery of excess payment, and your claim denials and appeals procedures.

In performing its obligation to process and adjudicate claims for plan benefits, CIGNA HealthCare is the claims fiduciary. As such, CIGNA HealthCare has the sole authority and discretion to determine whether submitted claims are eligible for benefits and to interpret, construe, and apply the provisions of the Plan in processing and adjudicating claims, including appeals. Determination by CIGNA HealthCare is conclusive and not subject to review by Sandia. Upon written request, and free of charge, members may examine documents relevant to their claims/appeals and submit opinions and comments.

Covered members who become eligible for ***Medicare*** primary coverage should enroll in ***Medicare*** Parts A and B. Once a ***covered member*** becomes eligible for ***Medicare*** primary coverage, Sandia will pay benefits only as secondary payer of benefits, regardless of whether the ***member*** enrolled in ***Medicare*** Parts A and B.

Important

*If a **covered member** who is eligible for **Medicare** primary coverage is provided primary coverage under this or any other Sandia-sponsored medical plan, the primary **covered member** will be responsible for reimbursing Sandia for any ineligible benefits.*

Obtaining Reimbursement

In general, you will not need to file claims under the CIGNA In-Network Plan (you pay your ***copay*** at the time service is provided). Check with your ***providers*** to verify that they will submit your claims.

You may need to file a claim in certain situations, such as for ***emergency*** care while you are on travel. To obtain reimbursement for medical care, attach the itemized medical bill to the claim form and mail it to the address shown on the claim form or to the address on the back of your ID card. Itemized medical bills should include:

- Patient's full name
- Data and place of treatment or purchase
- Diagnosis
- Type of service provided
- Amount charged
- Name and address of ***provider*** and tax identification number, if available

- A copy of the EOB (from the primary insurer, if other insurance is primary) attached to your claim form

How to Submit Claim Forms

You only need to complete the claim form if the ***provider*** is **not** submitting it for you. To obtain a form:

- visit Sandia HBES in Building 832 East or call them at (505) 844-4237
- call CIGNA HealthCare at 1-800-244-6224 or go online at www.cigna.com

If you are completing the form by hand, use a new printed form rather than a photocopy, and be sure to print clearly and use black ink when you complete the form as this ensures that the claim form can be scanned into the system. Follow the instructions that come with the claim form in submitting your claim. The address to mail your claim is on the back of your ID card.

Benefits Payment

CIGNA HealthCare will send payment to the ***provider***, unless the ***provider*** is not contracted with CIGNA and you submit a receipt that shows you paid in full (a zero balance) with your itemized bill and the claim form. CIGNA reserves the right to request additional documentation, such as medical records, prior to processing your claim.

Note: The person who received the service is ultimately responsible for payment of services received from ***providers***.

Benefits payments shall be made to the estate of a ***covered member*** or to any relative or other person the Plan determines to have accepted competent responsibility for a minor or individual who is incompetent to give a valid release or as otherwise required by law. Any payment made by the Plan in good faith pursuant to the provision shall fully discharge the Plan and the company to the extent of such payment.

Members cannot assign, pledge, borrow against, or otherwise promise any benefit payable under the Plan before receipt of that benefit. Interest in the Plan is not subject to the claims of creditors. Exceptions include:

- A ***QMCSO*** that requires a health plan to provide benefits to the ***primary covered member's child***
- Subject to the written direction of a ***primary covered member***, all or a portion of benefits provided by the Plan may, at the option of the Plan and unless the individual requests otherwise in writing, be paid directly to the person rendering such service. Any payment made by the Plan in good faith pursuant to this provision shall fully discharge the Plan and the company to the extent of such payment.

CIGNA HealthCare will send the ***covered member*** an EOB after processing the claim. The EOB will let the ***covered member*** know if there is a balance due by the patient. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. You can also view and print your EOBs online at mycigna.com.

Important

*All claims must be submitted within 12 months after the date of service in order to be eligible for consideration of payment. The 12-month requirement will not apply if you are legally incapacitated. If your claim relates to an **inpatient** stay, the date of service is the date your **inpatient** stay ends.*

Timing of Claims Payments

Separate schedules apply to the timing of claims, depending on the type of claim. There are four types of claims:

- Urgent care—a claim for benefits provided in connection with ***urgent care services***
- Pre-service—a claim for benefits that the Plan must approve before ***nonurgent care*** is provided
- Concurrent care—a claim for benefits whereby the Plan had been reimbursing for the care and a determination was made that the care was no longer eligible for reimbursement
- Post-service—a claim for reimbursement of the cost of ***nonurgent care*** that has already been provided.

Urgent Care Claims

Time Frame for Response from CIGNA HealthCare

Urgent claims will be decided on as soon as possible. Notice of the decision (whether adverse or not) must be provided, considering medical exigencies, no later than 72 hours after receipt of the claim.

Extension

If additional information is needed to make a claim decision, CIGNA HealthCare may extend the time frame for providing a response by up to 48 hours from the time the information is received or the initial period expires.

Period for Claimant to Complete Claim

If an extension in processing is required because the claimant has failed to submit sufficient information to allow determination of the claim, the claimant has at least 48 hours after receipt of notice to provide missing information.

Other Related Notices

Notice that a claim is improperly filed or is missing information must be provided as soon as possible but no later than 24 hours from receipt of claim.

Nonurgent Pre-service Claims

Time Frame for Response from CIGNA HealthCare

Pre-service determination of benefit (whether adverse or not) must be provided within a reasonable period of time, appropriate to medical circumstance, but no later than 15 days.

Extension

CIGNA HealthCare may extend the original time frame by up to 15 days if necessary due to matters beyond the Plan's control. CIGNA HealthCare must notify the claimant of the extension before the initial period ends.

Period for Claimant to Complete Claim

If an extension in processing is required because the claimant has failed to submit sufficient information to allow determination of the claim, the claimant will be so notified and given at least 45 days from the notice to provide missing information.

Nonurgent Post-service Claims

Time Frame for Response from CIGNA HealthCare

Post-service claim decision notices (whether adverse or not) must be provided within a reasonable period of time but no later than 30 days.

Extension

CIGNA HealthCare may extend the original time frame by up to 15 days if necessary due to matters beyond the Plan's control. CIGNA HealthCare must notify the claimant of the extension before the initial period ends.

Period for Claimant to Complete Claim

If an extension in processing time is required because the claimant has failed to submit sufficient information to allow determination of the claim, the claimant will be so notified and given at least 45 days from receipt of the notice to provide missing information.

CIGNA HealthCare may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond the Plan's control.

Concurrent Care Claims

Time Frame for Response from CIGNA HealthCare

Concurrent care adverse claim decisions must be provided sufficiently in advance to give claimants an opportunity to appeal and obtain a decision before the benefit is reduced or terminated. A request to extend a course of treatment will receive a response within 24 hours if the claim is made at least 24 hours prior to the expiration of the period of time or number of treatments. The Plan provides that the benefit reimbursement be maintained for up to 60 calendar days from the date of the first letter of denial for sufficient time for the member to appeal.

Contents of Notice and Response from CIGNA HealthCare

The notice will include all of the following:

- Specific reasons for the denial
- Specific references to the Plan provisions upon which the denial is based
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation why the material/information is necessary
- An explanation of the Plan's appeal procedure, its deadlines, including, if applicable, the expedited review available for urgent claims, and the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse decision on appeal
- A copy of any rule or guideline relied upon in making the adverse determination, or a statement that the rule or guideline was relied upon, will be provided, upon request, free of charge
- An explanation of the specific or clinical judgment for the adverse determination whether based on a medical necessity or ***experimental*** treatment or similar exclusion or limit by applying the terms of the Plan to the medical circumstances, or a statement that such explanation will be provided free of charge upon request

Claims Denials and Appeal

Sandia is committed to capturing, as error-free as possible, the information you provide us. CIGNA HealthCare uses this information to review and process your claims as quickly and accurately as possible.

If CIGNA HealthCare denies your (or your dependent's) claim because of eligibility, refer to Section 2, Eligibility, for eligibility appeals procedures.

If you dispute CIGNA HealthCare's denial of your claim based on Plan coverage, or you want to challenge a benefit determination, you have the right to request that CIGNA HealthCare reconsider its decision. The procedure for appealing to CIGNA HealthCare is outlined below.

If your claim is denied because of…	then…
coverage eligibility (except for disability determinations)	contact Sandia HBES at (505) 844-4237.
benefits administration or any other reason	contact CIGNA HealthCare at 1-800-244-6224.

Filing an Appeal

If a claim for benefits is denied in part or in whole, you have the right to appeal the claim. CIGNA HealthCare will conduct a full and fair review of your appeal.

Regardless of the decision and/or recommendation of CIGNA HealthCare, or what the plan will pay, it is always up to the member and the doctor to decide what, if any, care is received.

CIGNA HealthCare has established procedures for hearing, researching, recording, and resolving any appeals or complaints a member may have. The appeals procedure is limited to members and to former members seeking to resolve a dispute that arose during coverage.

For urgent claims that have been denied, you or your ***provider*** may call CIGNA HealthCare at 1-800-244-6224.

If you wish to appeal a denied claim, you must submit your appeal, in writing, within 180 calendar days of receiving the denial. The written communication should include:

- Patient's name and ID number as shown on the ID card
- ***Provider's*** name
- Date of medical service
- Reason you think your claim should be paid
- Any documentation or other written information to support your request.

Send the written appeal to:

CIGNA HealthCare
Appeals Department
700 N. Brand Blvd.
Glendale, CA 91203

Two levels of appeals are permitted for each type of claim that is denied. These are described in the following steps:

Step 1: First Level of Appeal

- CIGNA HealthCare will attempt to resolve the complaint informally through review of previous medical information received, physician office records, and additional medical information requested from the physicians.
- Treatment may be reviewed by another physician, with the same specialty, who was not consulted during the initial benefit determination.

Step 2: Second Level of Appeal

- If you are not satisfied with the first-level appeal decision, you have the right to request a second-level appeal within 60 days from receipt of the first-level appeal.

Timing of Appeals Decisions

Separate schedules apply to the timing of claims appeals, depending on the type of claim: ***urgent care***, pre-service, or post-service claims. If the claimant does not receive a written response from CIGNA HealthCare within the time periods described above, the claimant should treat the claim as denied and proceed immediately to the next level of appeal, request an external review, or seek legal recourse.

Important

You must exhaust the appeal process before you request an external review or seek other legal recourse.

Urgent Care Claims

Period for Filing Appeals

The claimant has at least 180 days for filing the first level of appeal.

Note: You do not need to submit an ***urgent care*** claim appeals in writing. You should call CIGNA HealthCare as soon as possible to appeal an
urgent care claim.

Time Frame for Response from CIGNA HealthCare

Response must be provided as soon as possible taking into account medical exigencies, but no later than 72 hours. There is a maximum of two levels of mandatory review.

Nonurgent Pre-service Claims

Period for Filing Appeals

The claimant has at least 180 days for filing the first level of appeal.

Time Frame for Response from CIGNA HealthCare

Response must be provided within a reasonable period of time, appropriate to medical circumstance, but no later than 30 days. Response must be provided within 15 days of each appeal.

Nonurgent Post-service Claims

Period for Filing Appeals

The claimant has at least 180 days for filing the first level of appeal.

Time Frame for Response from CIGNA HealthCare

Response must be provided within a reasonable period of time, but no later than 60 days. A notice of adverse claim appeal must be provided within a reasonable period of time, but no later than 30 days after each appeal.

External Review

If you are not satisfied with the decision of the second-level appeal denial based upon lack of medical necessity or the ***experimental*** nature of the treatment, and if your claim was above $1,000, you may request that your claim be reviewed by an external independent review organization.

The independent review organization is composed of individuals who are not employed by CIGNA HealthCare or any of its affiliates. There is no charge for you to initiate this independent review process. CIGNA HealthCare will abide by the decision of the independent review.

Administrative eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process. To request a review, you must write to CIGNA HealthCare within 180 days of your receipt of the second-level appeal denial. You may provide additional information to be considered. CIGNA HealthCare will acknowledge receipt of your request and will notify you when your file has been sent to external review. The independent reviewer will render an opinion within 60 days upon receipt of all information. If you are not satisfied with the outcome of this review, you have the right to seek legal recourse.

Important

The claims administrator, CIGNA HealthCare, has the exclusive right to interpret the provisions of this Plan (with the exception of eligibility provisions), to construe its terms, to determine the amount and level of benefits to be paid, and to determine disability status as required for continuation as Class I dependent after age 24. CIGNA HealthCare's determination is conclusive and binding.

Other Insurance Request for Dependents

Beginning January 1 of every year, or if you are a new enrollee, CIGNA HealthCare will require an update on whether your covered dependents have other insurance. This information needs to be provided even if your dependents do not have other insurance. CIGNA HealthCare will pay claims and request verification from the primary ***covered member*** for other insurance. Claims will be held when a $500 threshold is met until the information is received. You may update your other insurance information by going online at mycigna.com or by calling CIGNA HealthCare at 1-800-244-6224.

Recovery of Excess Payment

The CIGNA HealthCare ***claims administrator*** has the right at any time to recover any amount paid by this plan for charges in excess of the covered benefits under the Plan provisions. Payments may be recovered from ***covered members***, ***providers*** of service, and other medical care plans.

Important

*By accepting benefits under this Plan, the **covered member** agrees to reimburse payments made in error and cooperate in the recovery of excess payments.*

Section 12. When Coverage Stops

This section outlines when coverage stops for employees, retirees, and Class I dependents as well as causes for coverage termination. See Section 13, Continuation of Group Health Coverage, for specific rules governing when health coverage stops and how it may be continued for:

- Surviving spouse
- ***Covered members*** on ***leave of absence***
- LTD terminees
- ***Covered members*** paying for coverage under temporary continued coverage under ***COBRA***

Active Employees and Retirees

Plan benefits for active employees and retirees stop on the:

- Last day of the month that the employee's ***leave of absence*** or termination of employment becomes effective, except as provided under temporary continuation of coverage under ***COBRA*** or otherwise provided by law or by the provisions of this SPD
- Date the Plan is terminated
- Last day of the month in which any cost of the coverage is not paid when due
- Date of death
- Last day of the month in which the retiree becomes eligible for ***Medicare*** primary coverage
- Submission of a fraudulent claim

Important

Health care coverage may be continued in some situations (refer to Section 13, Continuation of Group Health Coverage, for COBRA rules). Special rules apply to leaves of absence for family and medical care (see Family and Medical Leave Act) and for military service (see Uniformed Services Employment and Reemployment Rights Act).

Class I Dependents

Plan benefits for dependents under this Plan stop on the:

- Last day of the month in which the dependent becomes eligible for coverage as an employee under any Sandia-sponsored medical plan
- Last day of the month that costs for dependent coverage are not paid when due

- Date primary ***covered member***'s (employee or retiree) coverage stops
- Last day of the month in which the dependent spouse legally divorces or affects a legal separation or an annulment from the primary ***covered member*** (employee or retiree)
- Last day of the month in which the dependent becomes eligible for ***Medicare*** primary coverage
- Last day of the month in which a dependent ***child*** marries or ceases to be eligible under the definition of dependent
- Last day of the month in which the primary ***covered member*** (employee or retiree) terminates (disenrolls)dependent coverage
- Date of death
- Submission of a fraudulent claim

Note: You must disenroll your dependents within 31 calendar days of the date your dependent becomes ineligible for coverage under this Plan.

Refer to Section 13, Continuation of Group Health Coverage, to determine whether your dependent may be eligible for temporary continued coverage under ***COBRA***, and refer to the Pre-Tax Premium Plan booklet for specific rules regarding dropping dependent coverage if premiums for medical coverage are taken on a pre-tax basis.

Termination for Cause

The CIGNA HealthCare ***claims administrator*** may terminate a ***member's*** coverage for cause, upon 30 days written notice, or with written notice effective immediately for gross misconduct. Cause for termination of a ***member*** may include any of the following:

- Failure to pay ***copays***
- Permitting an unauthorized person to use your ID card (unless you notified CIGNA HealthCare to report that your card was lost or stolen)
- Repeated failure to make or keep appointments for medical care
- Declination of Plan benefits
- Abuse of Plan coverage by providing false information on applications or forms
- Failure to follow Plan rules and regulations
- Verbal or physical threats to CIGNA HealthCare employees, physicians, or network ***providers***
- Fraudulent receipt of Plan services for noncovered persons
- Failure to comply with ***subrogation*** rules

Covered members terminated for cause are not eligible for any of this Plan's continuation of group health coverage.

Certificate of Group Health Plan Coverage

Sandia complies with the requirements of the Health Insurance Portability and Accountability Act, Pub. L. 104-191, enacted on August 21, 1996. ***HIPAA*** amended the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986. The amendment provides for, among other things, improved portability and continuity of health insurance coverage in the group and individual insurance markets, and group health plan coverage provided in connection with employment.

When Sandia Benefits learns of your loss of medical coverage, or the loss of coverage for your dependents, you will receive a Certificate of Group Health Plan Coverage. This certificate provides proof of your prior health care coverage for the past 18 months or less. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions that you have before you enroll. This certificate may need to be provided if medical advice, diagnosis, care, or treatment was recommended or received for the condition within the six-month period before your enrollment in the new plan. If you become covered under another group health plan, check with the Plan administrator to see if you need to provide this certificate. You may also need this certificate to buy an insurance policy for yourself or your covered family member that does not exclude coverage for medical conditions that are present before you enroll.

You have up to two years following the event that caused you to lose coverage to request a Certificate of Group Health Plan Coverage.

Section 13. Continuation of Group Health Coverage

This section outlines the opportunities that Sandia gives the employee, the employee's spouse or former spouse, and the employee's dependent ***children*** to continue Sandia-sponsored health coverage where group health coverage would otherwise end.

Continued employer-provided health coverage is subject to the stated qualifications and requirements of participation in each Sandia health plan. Sandia offers the following ***covered members*** the opportunity to continue group health coverage under this Plan when coverage would otherwise end:

- Employees on leaves of absence
- Employees who retire
- Employees who are approved for and receiving long-term disability through Sandia
- Surviving spouse and dependents
- ***COBRA***-eligible persons

During Leaves of Absence

If you take a ***leave of absence***, you are eligible to continue the same medical coverage you had as an active employee. You will be allowed to change your medical plan choice every year during the ***open enrollment*** period Sandia holds in the fall.

Note: Refer to CPR 300.6.18, Leaves of Absence, for more detail.

Sandia offers you an opportunity to continue your Sandia-sponsored medical coverage while you are on the following approved leaves of absence:

- **Child Care**—to care for a newborn child, a newly adopted child, or a newly placed foster child
- **Family Care**—to care for a seriously ill or injured family member
- **Military Service**—for service in the Uniformed Services of the United States or with the National Guard
- **Tribal Government Appointments**—to accept a tribal government appointment: tribal governor, lieutenant governor, tribal secretary, or tribal treasurer
- **Personal**—to take care of urgent personal matters
- **Personal (educational)**—to pursue higher education goals

- **Special**—to accept assignment with the government, another DOE contractor, or a college or university

Refer to Section 4, Group Health Plan Premiums, for information on the premiums for continued medical coverage under this Plan while you are on a ***leave of absence***. Contact Sandia HBES at (505) 844-4237 for more information.

Important

*Coverage during the **leave of absence** runs concurrently with (i.e., applies toward) the temporary continued coverage under COBRA. If you terminate employment at the end of the leave, additional coverage months may be available under COBRA depending on the number of months taken for the leave. You will receive a COBRA notice and election at the time your leave begins (as described under COBRA later in this section), and you will need to submit that election in order to take advantage of continued coverage during your leave.*

Retiree Medical Plan Option

If you retire from Sandia with a service pension or a disability pension, you are eligible for continued medical coverage through Sandia under the Retiree Medical Plan Option. You will be allowed to change your medical plan choice every year during the ***open enrollment*** period Sandia holds in the fall.

Upon retirement, if you are not eligible for ***Medicare*** primary coverage, the Retiree Medical Plan Option allows you to enroll in either this Plan or the CIGNA Premier PPO Plan. Unless you elect to enroll in the CIGNA Premier PPO Plan within 31 calendar days of your retirement date, this Plan will be your primary medical coverage until you reach age 65 or you become disabled and are eligible for ***Medicare*** primary coverage. You will no longer be eligible for this Plan, but you may be eligible for the CIGNA Senior Premier PPO Plan. The ***Medicare*** primary covered retiree and/or covered dependents will be defaulted into the CIGNA Senior Premier PPO if an election is not made.

All ***Medicare*** primary family members must be enrolled in the same plan, and all non-***Medicare*** primary family members must be enrolled in the same plan.

Note: If you are a ***dual Sandian*** and your spouse remains an employee, you have the option of enrolling as a dependent under your spouse; or, if your spouse is already a retiree, you can change your election as to who is covered under whom.

Important

*As an alternative to electing coverage under the Retiree Medical Plan Option, the retiree may elect to temporarily continue the same medical coverage as available to active employees by making an election under COBRA. If the retiree elects COBRA coverage instead of coverage under the Retiree Medical Plan Option, he/she **cannot** elect the Retiree Medical Plan Option after his/her COBRA coverage has terminated. If he/she elects the Retiree Medical Plan Option, he/she must waive his/her rights to COBRA.*

Long-Term Disability Terminee Medical Plan Option

If you terminate employment because of a disability and you are approved for and receiving long-term disability benefits through Sandia, you are eligible to continue medical coverage through Sandia until the end of the month in which you recover and the Plan benefit ceases, the Plan benefit ceases for any other reason, or you die. You will be allowed to change your medical plan choice every year during the ***open enrollment*** period Sandia holds in the fall.

If you are under age 65 and have been receiving Social Security disability benefits for 24 months or longer, or if you are age 65 or older, you are eligible for ***Medicare*** primary coverage. ***Medicare*** will become your primary coverage. You will no longer be eligible for this Plan but you may be eligible for the CIGNA Senior Premier PPO Plan or a ***Medicare*** Advantage Plan offered by Sandia if you enroll within 31 calendar days of becoming eligible for ***Medicare*** primary coverage. The ***Medicare*** primary disability terminee and/or covered dependents will be defaulted into the CIGNA Senior Premier PPO if an election is not made.

Important

As an alternative to electing coverage under the Long-Term Disability Terminee Medical Plan Option, the terminee may elect to temporarily continue the same medical coverage as available to active employees by making an election under COBRA. If the terminee elects COBRA coverage instead of coverage under the Long-Term Disability Terminee Medical Plan Option, he/she cannot elect the Long-Term Disability Terminee Medical Plan Option after his/her COBRA coverage has terminated. If he/she elects the Long-Term Disability Terminee Medical Plan Option, he/she must waive his/her rights to COBRA.

Surviving Spouse Medical Plan Option

If you are a survivor or dependent of an on-roll regular employee, or a Sandia retiree who dies while covered under this Plan, you are eligible to continue medical coverage through Sandia under the Surviving Spouse Medical Plan Option. You will be allowed to change

your medical plan choice every year during the ***open enrollment*** period Sandia holds in the fall.

Sandia pays a portion of the full premium for continued Sandia-sponsored health coverage for the first six months.

EXCEPTION

Sandia does NOT pay for the first six months of coverage for survivors of those retired employees paying their own premiums at the time of death.

The surviving spouse and dependents may continue medical coverage for life if the election to continue coverage is made within the first six months of death and the applicable survivor rate for medical coverage paid.

The surviving dependent ***children*** with no surviving parent may continue Sandia-sponsored medical coverage up to an additional 30 months of coverage (beyond the initial first six months at the applicable employee or retiree premium-share amount) by paying the ***COBRA*** rate for health coverage.

Important

*As an alternative to electing coverage under the Survivor Medical Plan Option, the surviving spouse and any surviving dependents may elect to temporarily continue the same medical coverage as available to active employees or non-**Medicare** primary retirees (whichever is applicable) by making an election under COBRA. If the surviving spouse elects COBRA coverage instead of coverage under the Survivor Medical Plan Option, the surviving spouse **cannot** elect the Survivor Medical Plan Option after his/her COBRA coverage has terminated. If the surviving spouse elects the Survivor Medical Plan Option, he/she must waive his or her/rights to COBRA.*

Special Rules

- All Class I dependents, covered at the time of death of the employee, are eligible for continued medical coverage through Sandia.
- No new dependents can be added **except** for ***children*** born or adopted with respect to a pregnancy or placement for adoption that occurred before the employee's or retiree's death.
- A survivor **cannot** add a ***Class II dependent*** even if that dependent is a Class I dependent at the time of the employee's or retiree's death.

Termination Rules

For the surviving spouse and dependents, coverage is terminated if:

- The spouse marries

- A surviving spouse dies

> **Note:** If a surviving spouse dies, any covered dependents under the spouse may have ***COBRA*** rights.

- Payments are not received when due

COBRA

The federal law known as the Consolidated Omnibus Budget Reconciliation Act (***COBRA***) requires Sandia to offer temporary continuation of the same group health coverage as previously in effect to the covered employee, retiree, or other former employee, and the covered spouse, and the covered dependent ***child(ren)*** of the employee, retiree, or other former employee when a ***qualifying event*** causes the individual to lose his/her group health coverage.

COBRA-qualified beneficiaries may continue medical coverage through Sandia by notifying Sandia of a ***qualifying event*** (other than termination, reduction of hours, or death of an employee). ***COBRA*** coverage will continue for qualified beneficiaries who pay the applicable ***COBRA*** rate, plus a two percent administrative fee, in a timely manner.

> **Note:** A dependent ***child*** who is born to or placed for adoption with the employee or retiree during a period of ***COBRA*** continuation coverage is a qualifying beneficiary.

Covered members who become eligible for ***Medicare*** primary coverage should enroll in ***Medicare*** Parts A and B. Once a ***covered member*** becomes eligible for ***Medicare*** primary coverage, Sandia will pay benefits **only** as secondary payer of benefits, regardless of whether the ***member*** enrolled in ***Medicare*** Parts A and B.

Important

*If a **covered member** who is eligible for **Medicare**-primary coverage is provided primary coverage under this or any other Sandia-sponsored medical plan, the primary **covered member** will be responsible for reimbursing Sandia for any ineligible benefits.*

Qualifying Events Causing Loss of Coverage

The following table describes how an individual may become a ***qualified beneficiary*** due to the events causing loss of coverage and thus making those individuals eligible for continued medical coverage through Sandia and the maximum period of continuation coverage that is available under ***COBRA***.

You are a qualified beneficiary if you are the…	and if you, a covered member, lose coverage under this Plan due to…	your maximum period of continuation coverage is…
employee spouse dependent child	• termination of employee's employment for any reason other than gross misconduct • reduction in employee's hours of employment	18 months*
employee spouse dependent child	• termination of employment (for any reason other than gross misconduct or reduction in employee's hours of employment) a. and you are disabled or become disabled within the first 60 days of your COBRA coverage, as determined by Social Security b. and you do not have Medicare coverage.[1]	29 months from the original COBRA qualifying event (after the first 18 months you will be charged 150% of the cost of the applicable group rate)
spouse dependent child	• covered employee, retiree, or LTD terminee becoming entitled to Medicare • divorce or legal separation of the spouse from the covered employee, retiree, or LTD terminee • death of the covered employee, retiree, or long-term disability terminee	36 months
dependent child	• loss of dependent child status under the Plan rules	36 months
*You may become entitled to an 18-month extension of your COBRA coverage (for a total maximum period of 36 months of continuation coverage) if you experience a second qualifying event such as the death of the primary qualified beneficiary, the divorce or legal separation from the primary qualified beneficiary, the primary qualified beneficiary becoming entitled to Medicare, or a loss of dependent child status under the plan.		

The second event can be a second ***qualifying event*** only if it would have caused you to lose coverage under the Plan in the absence of the first ***qualifying event***. If a second ***qualifying event*** occurs, you will need to notify the Plan.

[1] You must notify Sandia Benefits at (505) 844-4237 within 60 days of the date Social Security determines that you or a family member is disabled and within the first 18 months of COBRA continuation of coverage. If you fail to notify Sandia, you will lose your right to the additional COBRA coverage. If you fail to inform Sandia Benefits within 60 days of the notification date, you will no longer be eligible to participate in COBRA.

Notification of Election of COBRA

The following table shows notification and election actions for temporary continued coverage under ***COBRA***.

Step	Who	Action
1	Employee or family member	Notify Sandia Benefits, in writing, within 60 days[1] after the date on which the following qualifying event occurs: • Divorce • Legal separation • Annulment • Loss of a child's dependent status • Disability designation by Social Security Send notice to: Sandia National Laboratories Attention: Benefits Department, Mail Stop 1022 Albuquerque, NM 87185
2	Sandia Benefits	Notify Sandia Benefits COBRA administrator of covered member's qualifying event (including termination, reduction of hours of employment, death of employee, etc.)
3	Sandia Benefits COBRA Administrator	Notify qualified beneficiaries of their right to continue medical coverage through Sandia and how to make an election. The notice must be provided to qualified beneficiaries within 14 days after the COBRA administrator receives the notice of a qualifying event. Contact the COBRA administrator by calling Sandia HBES at (505) 844-4237.
4	Qualified Beneficiary	Contact the Sandia Benefits COBRA administrator to elect COBRA coverage. • Qualified beneficiary has 60 days to elect COBRA starting on the later of the date he/she is furnished the COBRA rights notice or the date he/she would lose coverage. • Qualified beneficiary must make initial premium payment within 45 days from the COBRA election date. The plan allows a 30-day grace period for monthly premium payment thereafter. • If you elect to continue, Sandia provides coverage

[1] You must notify Sandia Benefits at (505) 844-4237 within 60 days of the date Social Security determines that you or a family member is disabled and within the first 18 months of COBRA continuation of coverage. If you fail to notify Sandia, you will lose your right to the additional COBRA coverage. If you fail to inform Sandia Benefits within 60 days of the notification date, you will no longer be eligible to participate in COBRA.

Step	Who	Action
		under the Plan at your expense plus the applicable administrative fee. • If you do not elect to continue coverage during the 60-day election period, medical coverage through Sandia ends at the end of the month in which the event occurred and the qualified beneficiary became ineligible for coverage. • Failure to make any payment within the payment date requirement described above will cause you to lose all COBRA rights. • Following the initial payment, if you do not pay a premium by the first day of a period of coverage, the plan has the option to cancel your coverage until payment is received, and then reinstate the coverage retroactively back to the beginning of the period of coverage. Retroactive reinstatement is not available unless payment is received within 30 calendar days of the due date. • If the amount of payment is wrong, but is not significantly less than the amount due, the plan is required to notify you of the deficiency and grant a period of no longer than 30 days to pay the difference. The plan is not obligated to send monthly premium notices.
5	Sandia Benefits COBRA Administrator	Notify qualified beneficiaries of early termination of COBRA continuation coverage if it will end prior to the maximum period that COBRA coverage is available.

Benefits Under Temporary Continuation Coverage

As a ***qualified beneficiary*** you have the following rights under ***COBRA***:

- Identical coverage that is currently available under the plan to similarly situated employees, retirees, and their families
- Same benefits, choices, and services that a similarly situated member or beneficiary is currently receiving under the Plan, such as the right during the annual ***open enrollment*** period Sandia holds each fall to choose among available coverage options
- Subject to the same rules and limits that would apply to a similarly situated member or beneficiary, such as ***copay*** requirements, ***deductibles***, and coverage limits. The Plan's rules for filing benefit claims and appealing any claims denials also apply.

Any changes made to the Plan's terms that apply to similarly situated employees, retirees, and their families will also apply to qualified beneficiaries receiving ***COBRA*** continuation coverage.

Termination of Temporary Continuation Coverage

Early termination of continuation coverage may occur for any of the following reasons:

- Premiums are not paid in full on a timely basis
- Sandia ceases to maintain any group health plan
- A ***qualified beneficiary*** begins coverage under another group health plan after electing continuation coverage under Sandia, and that plan does not impose an exclusion or limitation affecting a pre-existing condition of the ***qualified beneficiary***
- A ***qualified beneficiary*** becomes entitled to ***Medicare*** benefits after electing continuation coverage
- A ***qualified beneficiary*** engages in conduct that would justify the plan in terminating coverage of a similarly situated member or beneficiary not receiving continuation coverage (such as fraud)

Coverage extensions required under other laws (e.g., state law) or provided by other provisions of the Plan, such as leaves of absence (excludes FMLA), continue concurrently with (i.e., count toward) temporary continued coverage, mandated by ***COBRA***.

Disability Extension and Multiple Qualifying Events

COBRA coverage may be extended (as previously discussed) under the following circumstances:

- If an individual is Social Security disabled before or during the first 60 days of an 18-month ***COBRA*** period, all of the individual's ***COBRA***-eligible family is eligible for an 11-month extension of coverage up to a maximum of 29 months from the original ***COBRA qualifying event***. After the first 18 months of ***COBRA*** coverage, he/she will be charged at 150 percent of the cost of the applicable group rate.

  The individual must provide a copy of the Social Security determination within 60 days of the date the disability determination was made and no later than 18 months after the election change event. He/she must also provide notice within 30 days of determination that the ***qualified beneficiary*** is no longer disabled.

- In the event a second election change event (e.g., divorce, primary ***qualified beneficiary*** dies or becomes covered by ***Medicare***, dependent ***child*** loses dependent status) occurs during the 18-month ***COBRA*** coverage period (or during disability extension), the spouse and ***children*** already receiving continuation coverage may be eligible for additional months of coverage, up to a maximum of 36 months from the date of the original election change event. The employee must notify Sandia Benefits of the second election change event within 60 days.

Section 14. CIGNA HealthCare Services

This section outlines the customer services provided by CIGNA HealthCare to ***covered members***.

Member Services

Member services are provided through CIGNA HealthCare Member Services at 1-800-244-6224, Monday through Friday, from 8:00 a.m. to 6:00 p.m. (MST) and include:

- Benefits information
- Claims status
- ID cards
- Pre-certification
- Prior authorization
- ***Provider*** searches
- Utilization review

If you are not satisfied with Member Services, a CIGNA representative is available to assist ***covered members*** with day-to-day questions and issues, including explanation of plan provisions, network ***providers***, access to care, billing issues, appeals, and referrals to case management. Call Sandia HBES at (505) 844-4237 to get in touch with a CIGNA representative.

CIGNA Open Access Plus ID Card

CIGNA HealthCare provides each ***covered member*** an ID card that shows his/her Plan participation and certain coverage levels, such as ***copay*** amounts, on the front. The back of the card shows the CIGNA HealthCare Member Services number and the address to file claims. To facilitate efficiency of service provided:

- To help ensure that your claims are handled properly, carry your ID card with you at all times and show it whenever you access medical care, including a:
    - Physician or ***specialist***
    - ***Hospital***
    - Lab, X-ray, mammography, MRI, or other facility
    - Emergency room

Hospital Admissions

Call CIGNA HealthCare at 1-800-244-6224 whenever you are hospitalized. It is your responsibility to make sure that you have received the necessary authorization, called precertification, for your ***hospital*** stay. Call CIGNA HealthCare at a minimum of five days before a scheduled admission. If you are unable to call five days in advance, you should call as soon as you know you will need ***hospital*** care. The phone number is on your CIGNA HealthCare ID card.

If the service is for mental health or ***substance abuse*** services, ask to speak with a CIGNA Behavioral Health Customer Service representative.

CIGNA HealthCare Healthy Babies®

Call the CIGNA phone number on the back of your ID card to enroll in the CIGNA HealthCare Health Babies® program.

Case Management

CIGNA HealthCare offers case management services to ***covered member*** for needs beyond a traditional ***hospital*** stay. An experienced case manager offers valuable counseling, support, and care coordination. The case manager works with you and your doctor to sort out your options, contact facilities, arrange care, and access community resources and programs. The case manager can help you find cost-effective, quality, appropriate care for home care, ***outpatient*** treatment, or rehabilitation. Call the CIGNA phone number on the back of your ID card to learn more about case management.

Emergencies

Call 911 immediately or have someone call for you. Don’t delay!

Emergencies are covered under this Plan 24 hours a day, seven days a week, no matter where you are. Whenever a ***covered member*** has a serious accident or sudden ***illness***, and symptoms are severe and occur unexpectedly, seek medical help immediately.

Examples of ***emergency*** situations include:

- Uncontrolled bleeding
- Seizure or loss of consciousness
- Shortness of breath
- Chest pain or squeezing sensation in the chests
- Suspected overdose of medication or poisoning

- Sudden paralysis or slurred speech
- Severe burns
- Broken bones
- Severe pain

Call CIGNA HealthCare at 1-800-244-6244. You may also have someone call for you within 48 hours or as soon as possible.

If you have any questions about your situation and whether it is an ***emergency***, call your personal doctor.

Urgent Care

Call your personal doctor for prompt medical attention for severe sore throat, ear or eye infection, sprains or strains, and fever. Your personal doctor may recommend steps you can take to be more comfortable and may prescribe medication if necessary. If you need to be examined, your doctor will direct you to the most appropriate type of care—***emergency*** room, ***urgent care*** center, or office visit.

Routine Care

Routine physicals, immunizations, colds, flu, follow-ups for injuries or broken bones, and prescription needs are all situations that should be handled through regular, scheduled office visits with your doctor.

CIGNA HealthCare 24-Hour Health Information Line

The Health Information Line is available from anywhere in the U.S. 24 hours a day, seven days a week. Call 1-800-564-9286 to learn more about hundreds of topics, such as bumps, bug bites, back pain, elder care, and cardiology. Simple menus guide you to the information you need.

- Programs are updated regularly and are based on current medical research and treatments.
- You can listen to as many programs as you like.
- If you'd like more information or have a question, the system will automatically connect you with a registered nurse.

The Health Information line is available any hour of the day or night for:

- Detailed answers to your specific health questions
- Helpful home care suggestions
- Help in choosing the most appropriate care—***emergency*** room, ***urgent care***, or a doctor's office visit
- Help in locating nearby ***participating providers*** when you're away from home

Prescription Drug Coverage

This Plan provides prescription drug coverage. Simply take your prescription from your doctor, along with your CIGNA HealthCare ID card, to a participating pharmacy. All you'll pay is the applicable ***copay*** amount for covered prescriptions. Your CIGNA Healthcare ID card is accepted at more than 51,000 pharmacies nationwide, including local drug stores and national chains. Check the CIGNA HealthCare Provider Directory or visit the CIGNA website at mycigna.com to find a network pharmacy.

CIGNA HealthCare (mycigna.com)

By registering at mycigna.com, you can access your personalized information and get the most recently updated provider directories for physicians, ***specialists***, ***behavioral health***, and facilities.

If your ***provider*** is not contracted with CIGNA, he/she can access information about becoming contracted through cigna.com or by calling 1-888-882-4462.

The following information and resources are available to ***members*** at mycigna.com:

- **Plan Benefits**—view claim status, order ID cards or print a temporary one, locate contracted ***providers***, learn about plan benefits and features, and get answers to frequently asked questions
- **Health Quotient**—get a health profile by completing a brief, online Health Risk Assessment. Print the results to share with your ***provider***
- **Health Tracker**—record and track your personal medical data
- **Quality Care Tool**—find information about how ***hospitals*** rank by number of procedures performed, patients' average length of say, and cost.

Appendix A. Acronyms and Definitions

Acronyms

COB	coordination of benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act
CPR	corporate process requirement
DME	durable medical equipment
EAP	Employee Assistance Program
EBC	Employee Benefits Committee
ERISA	Employee Retirement Income Security Act
EOB	explanation of benefits
FMLA	Family and Medical Leave Act
HIPAA	Health Insurance Portability and Accountability Act
HBES	Health, Benefits, and Employee Services
ICD-9	International Classification of Diseases – 9th edition
ID	identification
IRS	Internal Revenue Service
IRC	Internal Revenue Code
LTD	Long-Term Disability
OB/GYN	obstetrical/gynecological
PCP	primary care physician
PKU	Phenylketonuria
PPO	Preferred Provider Organization
QMCSO	Qualified Medical Child Support Order
SPD	Summary Plan Description
U&C	usual and customary
VSIP	voluntary separation incentive program

Definitions

alternate payee/recipient

A child or custodial parent who is not a primary covered member and who, because of a Qualified National Medical Support Notice, is entitled to receive reimbursement directly from CIGNA HealthCare.

behavioral health

mental health and/or substance abuse

child(ren)

Child(ren) include:

- The primary covered member's or your domestic partner's own children and legally adopted children
- Adopted child (if the placement agreement and/or final adoption papers have been completed and submitted to Sandia Benefits)
- Stepchildren living with the primary covered member (stepchildren visiting for the summer are not considered to be living with you) including your domestic partner's stepchildren
- Child for whom the primary covered member or your domestic partner have legal guardianship
- Natural child, legally adopted child, or child for whom the primary covered member or your domestic partner have legal guardianship if a court decree requires you to provide coverage

claims administrator

CIGNA HealthCare and/or CIGNA Behavioral Health

COBRA

Requires Sandia to offer a temporary extension of health care coverage to primary covered members and dependents who would otherwise lose their group health coverage as a result of certain events

coinsurance

Cost-sharing feature by which the Plan pays a percentage of the covered charge, and the covered member pays the balance of that covered charge

congenital anomaly

A physical developmental defect that is present at birth and is identified within the first 12 months of birth

coordination of benefits (COB)

When a covered member has medical coverage under other group health plans (including Medicare), the Plan benefits are reduced so that the total combined payments

	from all plans do not exceed 100% of the highest allowed U&C charges or the lowest negotiated fee.
copay	A flat per-service charge you pay for services such as doctor visits (HMOs usually have only copays)
cost effective	Least expensive equipment that performs the necessary function. Applies to DME and prosthetic appliances/ devices
cosmetic procedures	Procedures or services that change or improve appearance without significantly improving physiological function, as determined the by CIGNA HealthCare
covered charges	See covered health service
covered health service	Covered health services are those health services and supplies that are: • Provided for the purpose of preventing, diagnosing, or treating illness, injury, mental illness, substance abuse or their symptoms • Included in the Section 6, Coverage and Limitation • Provided to covered members who meet the Plan's eligibility requirements
covered member	An eligible employee, retiree, surviving spouse, or COBRA-covered person who has coverage under the Plan and his/her dependents who have coverage under the Plan

custodial care	Services or supplies, regardless of where or by whom they are provided, that
	• A person without medical skills or background could provide or could be trained to provide
	• Are provided mainly to help the covered member with daily living activities, including
	  • Walking, getting in and/or out of bed, exercising, and moving the covered member
	  • Bathing, using the toilet, administering enemas, dressing, and assisting with any other physical or oral hygiene needs
	  • Assistance with eating by utensil, tube, or gastrostomy

- Homemaking, such as preparation of meals or special diets, and house cleaning
- Acting as a companion or sitter
- Supervising the administration of medications that can usually be self-administered, including reminders of when to take such medications
- Provide a protective environment
- Are part of a maintenance treatment plan or are not part of an active treatment plan intended to or reasonably expected to improve in covered member's illness, injury, or functional ability
- Are provided for the convenience of the covered member or the caregiver or are provided because of the covered member's own home arrangement are not appropriate or adequate

deductible

The dollar amount you must pay each year before the Plan begins to pay benefits for certain covered expenses. The amount of the deductible depends upon the plan you select.

developmental care

Services or supplies, regardless of where or by whom they are provided, that

- Are provided to a member who has not previously reached the level of development expected for the member's age in the following area of major life activity:
  - Intellectual
  - Physical
  - Receptive and expressive language
  - Learning
  - Mobility
  - Self-direction
  - Capacity for independent living
  - Economic self-sufficiency
- Are not rehabilitative in nature (restoring fully developed skills that were lost or impaired due to injury or illness)
- Are educational in nature

domestic partner

Relationship of two individuals of the same gender who have a committed relationship of indefinite duration with mutual obligations akin to those of a marriage, which include financial responsibility for each other. You must provide documentation to the Benefits Office certifying your domestic partner relationship.

dual Sandians

Both spouses are employed by or retired from Sandia, or one spouse may be employed by Sandia and the other may be retired from Sandia

durable medical equipment (DME)

Equipment (e.g., hospital beds, wheelchairs, walkers, C-PAP machine, etc.) determined by CIGNA HealthCare to meet the following criteria:

- Prescribed by a licensed physician
- Medially appropriate
- Not primarily and customarily used for a non-medical purpose
- Designed for prolonged use
- Serves a specific therapeutic purpose in treatment of an injury or illness

EAP counselor

A licensed master's or PhD-level mental health clinician who provides information, assessment, short-term counseling, and referrals

eligible expenses

Charges for covered health services that are provided while the Plan is in effect, determined as follows:

- In-network benefits—contracted rates with the provider
- This provision does not apply if you receive covered health services from an out-of-network provider in an emergency. In that case, eligible expenses are the amounts billed by the provider, unless CIGNA HealthCare negotiates lower rates.
- Eligible expenses are subject to CIGNA HealthCare's reimbursement policy guidelines. You may request a copy of the guidelines related to your claim from CIGNA HealthCare.

emergency

See medical emergency

experimental/investigative

Any treatment, procedure, facility, equipment, drug, device, or supply not accepted as standard medical practice

	in the state in which services are provided. In addition, if federal or other governmental agency approval is required for use of any items and such approval was not granted at the time services were administered, the service is experimental. To be considered standard medical practice and not experimental or investigative, treatment must meet all five of the following criteria: • A technology must have final approval from the appropriate regulatory government bodies • The scientific evidence as published in peer-reviewed literature must permit conclusions concerning the effect of the technology on health outcomes • The technology must improve the net health outcome • The technology must be as beneficial as any established alternatives • The improvement must be attainable outside the investigational settings
financially dependent persons	Persons who receive more than 50% of their financial support, for the calendar year, from the primary covered member
follow-up care	Reexamination of, or maintenance of contact with, a patient at prescribed intervals following diagnosis or treatment
formulary	A list of preferred brand-name drugs that can meet a patient's clinical needs at a lower cost than other brand-name drugs
Health Care Reimbursement Spending Account	Pre-tax money set aside in a spending account to be used to help pay for health care expenses not reimbursed or only partially reimbursed by any medical, dental, vision plan, or other health insurance plan. This account can be used by active employees only.
hospice	A program, provided by a licensed facility or agency, that provides home health care, homemaker services, emotional support services, and other service to a terminally ill person whose life expectancy is six months or less as certified by the person's physician.

hospital

An institution, licensed as a hospital, that

- Maintains, on the premises, all facilities necessary for medical and surgical treatment
- Provides such treatment on an inpatient basis, for compensation, under the supervision of physicians
- Provides 24-hour service by registered graduate nurses

An institution that:

- Qualifies as a hospital, a psychiatric hospital, or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Hospitals

An institution that

- Specializes in treatment of mental illness, alcohol or drug abuse, or other related illness
- Provides residential treatment programs

- Is licensed in accordance with the laws of the appropriate legally authorized agency.

It does not include a hospital or institution or part of a hospital or institution that is licensed or used principally as a clinic, convalescent home, rest home, nursing home, home for the aged, halfway house, or board and care facilities.

hospital confinement

A medically necessary hospital stay of 24 consecutive hours or more in any single or multiple departments or parts of a hospital for the purpose of receiving any type of medical service. These requirements apply even if the hospital does not charge for daily room and board. How the hospital classified the stay is irrelevant as well.

Any hospital confinement satisfying this definition will be subject to all contract provisions relating to inpatient hospital services or admissions, including any applicable preadmission review requirements. Hospital stays or services not satisfying this definition will be considered under the contract provisions for outpatient services.

illness

A disease, disorder, or condition that requires treatment by a physician. For a female member, illness includes childbirth or pregnancy. The term illness as used in this

	plan description does not include mental illness or substance abuse, regardless of the cause or origin of the mental illness or substance abuse.
injury	Bodily damage from trauma other than illness, including all related conditions and recurrent symptoms
inpatient	A person who is formally admitted to a hospital, skilled nursing facility, or inpatient rehabilitation facility, and who occupies a hospital bed, crib, or bassinet while under observation, care, diagnosis, or treatment for at least a 24-hour confinement period
intensive outpatient services	A program that provides 9 to 20 hours per week (less than 4 hours per day) of professionally directed evaluation and/or treatment.
jaw joint disorder (TMJ)	Any misalignment, dysfunction, or other disorder of the jaw joint (or of the complex of muscles, nerves, and tissues related to that joint), including temporomandibular joint (TMJ) dysfunction, arthritis, or arthrosis; other craniomandibular joint disorders; and myofascial or orofacial pain syndrome. It does not include a fracture or dislocation that results from an injury.
leave of absence	An approved absence without pay of more than 30 consecutive calendar days
living with you	A person living in your home at least 50% of the year. Stepchildren visiting for the summer are not considered to be living with you.
long-term disability terminee	An employee who has been approved for and is receiving disability benefits under with Sandia's Long-Term Disability Plan or Sandia's Long-Term Disability Plus Plan
maintenance care	Treatment beyond the point where material or significant improvement is to be expected. The treatment results in no measurable or objective improvement. For modality treatments, such as nonsurgical spinal treatment or physical therapy, the treatment provides no evidence of lasting benefit; treatment provides only relief of symptoms.
medical emergency	A sudden and unforeseeable injury or illness that arises

	suddenly and, in the judgment of a reasonable person, requires immediate medical care and treatment, generally received within 24 hours of onset to avoid jeopardy to life or health
medically necessary	Services or supplies order by a physician or provided by a hospital, physician, or other provider that CIGNA has determined are: • Provided for the diagnosis or direct treatment of an injury or illness • Appropriate and consistent with symptoms and findings or diagnosis and treatment of an injury or illness, and not experimental or investigative • Provided in accordance with generally accepted medical practice on a national basis • Not solely for the convenience of the member, plan physicians, or other health care plan providers • The most appropriate supply or level of service that can be provided on a cost-effective basis including, but not limited to, inpatient versus outpatient care, electric versus manual wheelchair, surgical versus medical or other types of care • Allowable under the provisions of this Plan as prescribed by the member's physician

Important

The fact that a physician may provide, prescribe, order, recommend, or approve a service or supply does not in itself make the service or supply medically necessary or make the charge for it allowable even though the service or supply is not specifically listed as an exclusion in this Plan.

Medicare	A federal program administered by the Social Security Administration that provides benefits partially covering the cost of necessary medical care
Medicare eligible	Member is eligible to enroll in Medicare Parts A and B regardless of whether he or she enrolls
Medicare primary	Member is eligible to receive Medicare benefits first before Sandia's plan is required to pay, regardless of whether the member enrolled in Medicare Parts A and B
mid-year election change event	An event that allows a primary covered member to make certain changes to their health care coverage. Refer to the

	Pre-Tax Premium Plan booklet.
member	See covered member
morbid obesity	A condition in which an adult has been 100 pounds over normal weight (by CIGNA HealthCare's underwriting standards) for at least five years despite documented unsuccessful attempts to reduce under a physician-monitored diet
negotiated fee	A contractual fee agreed to by providers (see participating providers) or facilities and CIGNA HealthCare for service provided to CIGNA members
nonparticipating	Licensed provider or facility not contracted with or employed by CIGNA
nonsurgical spinal treatment	Detection or nonsurgical correction (by manual or mechanical means) of a condition of the vertebral column, including: • Distortion • Misalignment • Subluxation to relieve the effects of nerve interference resulting from or relates to such conditions of the vertebral column
open enrollment	The period of time every year when you have the option to change your medical coverage for the subsequent calendar year (normally held in the fall of each year).
out-of-pocket maximum	Covered member's financial responsibility for covered medical expenses before the Plan reimburses additional covered charges at 100% for the remaining portion of that calendar year
outpatient	A person who visits a clinic, emergency room, or health facility and receives health care without being admitted as an overnight patient (under a 24-hour stay)
outpatient surgery	Any invasive procedure performed in a hospital or surgical center setting when a patient is confined for a stay of less than 24 consecutive hours
outpatient surgery facility	A free-standing facility or one associated with a hospital or physician's office that is permanently equipped to per-

form surgery without requiring an overnight stay

partial hospitalization

A program that provides covered services to persons who are receiving professionally directed evaluation or treatment and who spend only part of a 24-hour period (but at least four hours per day) or 20 hours per week in a hospital or treatment center

participating provider

The health care professionals, hospitals, facilities, institutions, agencies, and practitioners contracted with CIGNA HealthCare to provide covered services and supplies to CIGNA HealthCare members

physician

Any of the following licensed practitioners who perform a service payable under this Plan:

- A doctor of medicine (MD), osteopathy (DO), podiatry (DPM), or chiropractic (DC)
- A licensed doctoral, clinical psychologist
- A master's-level counselor and licensed or certified social worker who is acting under the supervision of a doctor of medicine or a licensed doctoral, clinical psychologist
- A licensed physician's assistant (PA)
- A licensed nurse practitioner

Where required to cover by law, any other licensed practitioner who:

- Is acting within the scope of his or her license
- Performs a service that is payable under this Plan

A physician eligible for reimbursement by the Plan does not include a person who lives with you or is part of your family (you, your spouse, or a child, brother, sister, or parent of you or your spouse).

plan administrator

Sandia Corporation

plan sponsor

Sandia Corporation

post-secondary educational program

Students who are classified as graduate, professional, administrative or co-op; graduate engineering minorities; undergraduate co-op, general clerical, technical or business; and general laborer.

pre-certification

The process whereby the member calls CIGNA HealthCare to obtain prior approval for medical necessity and

	length of any hospital confinement
Pre-Tax Premium Plan	A Plan that allows employees to pay premiums on a pre-tax basis
primary care physician	The physician who coordinates and manages your total health care for routine physicals to hospitalizations, ensuring that you receive the most appropriate care for your medical needs. Your PCP may practice in Family Practice or Internal Medicine. Pediatrician and OB/GYN physicians are also considered those patients' PCP.
primary covered member	The person for whom the coverage is issued; that is, the Sandia employee, retiree, survivor, or the individual who is purchasing temporary continued coverage
primary plan	The plan that has the legal obligation to pay first when more than one health care plan is involved
prior approval	See prior authorization
prior authorization	Certain services require prior authorization from the Health Services department at CIGNA. Prior authorization is based upon clinical findings supporting medical necessity and benefit determination. The clinical information provided to the Health Services department aids in the medical review throughout the treatment.
provider	See physician
qualified beneficiary	An employee, spouse, or dependent covered the day before the qualifying event, to include a child who is born to or placed for adoption with the covered member during COBRA. Qualified beneficiaries must be given the same rights as similarly situated employees, retirees, and their families.
qualifying event	Under COBRA, an event that but for the COBRA requirements would result in the loss of coverage to a qualified beneficiary
Qualified Medical Child Support Order (QMCSO)	Upon receiving the QNMSN packet, the employer determines if the state agency has correctly completed the notice and if it meets the requirements for a QMCSO under ERISA. To be qualified, a medical support order

must clearly specify:

- The member's name and last-known address
- The name and address of each child covered by the order
- A reasonable description of the coverage to be provided, or the manner in which coverage will be determined
- The period for which the order applies

If the QNMSN lacks any of the required information, but that information is reasonable available to the employer, the employer should consider the QNMSN qualified and proceed with enrolling the child(ren) in the medical plan. If the information is not available, the employer will return the QNMSN to the issuing agency.

Qualified National Medical Support Notice (QNMSN)

The federal government mandates that all states use this standardized form to notify an employer to withhold premiums from an employee's income when a parent is ordered to provide health care coverage for his or her child(ren). The QNMSN is the notice employers receive from the state child support enforcement agency instructing them to enroll a child(ren) in available dependent health coverage. The QNMSN helps ensure children receive health care coverage when it is available and required as part of a child support order. It simplifues the work of employers and plan administrators by providing uniform documents requesting health care coverage.

reconstructive procedure

A procedure performed to address a physical impairment where the expected outcome is restored or improved function. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as reconstructive procedure.

Sandia-sponsored medical plans

For Employees: UnitedHealthcare Premier PPO, CIGNA Premier PPO, UnitedHealthcare Standard PPO, CIGNA In-Network Plan, and Kaiser HMO (CA only)

For non-Medicare Retirees (less than age 65): UnitedHealthcare Premier PPO, CIGNA Premier PPO, UnitedHealthcare High Deductible Health Plan, CIGNA In-Network Plan, and Kaiser HMO (CA only)

For Medicare Retirees (age 65 and older), LTD Terminees, Class IIs, and other Medicare-eligible Persons: UnitedHealthcare Senior Premier PPO, CIGNA

	Senior Premier PPO, Presbyterian MediCare PPO (NM only), Lovelace Senior Plan (NM only); Kaiser Senior Advantage Plan (CA only)
service area	The geographical area, approved by the appropriate staff agency, within which participating providers are accessible to members.
short-term counseling	For Sandia's EAP, one to eight problem assessment/counseling visits per member per calendar year. Individuals or dependents/families may access the visits separately if different problems are addressed.
skilled nursing care facility	An institution or that part of an institution that provides convalescent or nursing care and is, or could be, certified as a skilled nursing care facility under Medicare
sound natural teeth	Teeth that: • Are whole or properly restored • Are without impairment or periodontal disease • Are not in need of the treatment provided for reasons other than dental injury
specialist	A physician who provides specialty services such as a dermatologist, podiatrist, cardiologist, etc.
subrogation	The Plan's or CIGNA HealthCare's right to recover any Plan payments made because of illness or injury to you or your dependent caused by a third party's wrongful act or for negligence and for which you or your dependent have a right of action or later recovered said payments from the third party
substance abuse	Abuse by the individual of drugs, alcohol, or other chemicals to the point of addiction, which has been diagnosed as an illness by a licensed physician
term of employment	The current period of continuous employment as a regular employee. May include periods of prior service, temporary service, and absence (see CPR 300.6.21)
total disability or totally disabled	Because of an injury or illness: • You are completely and continuously unable to perform the material and substantial duties of

	your regular occupation and are not engaging in any work or occupation for wages or profit, or • Your dependent is: o Physically or mentally unable to perform all of the usual duties and activities (the normal activities of a person of the same age and gender who is in good health) o Not engaged in any work or occupation for wages or profit
urgent care	Care provided for medical events that are not life-threatening but require prompt medical attention. Examples of urgent situations include sprains, strains, vomiting, cramps, diarrhea, bumps, bruises, colds, fevers, small lacerations, minor burns, severe stomach pains, swollen glands, rashes, poison ivy, and back pain.
urgent care facility	Can be attached to a hospital or be free-standing, staffed by licensed physicians and nurses, and providing health care services
urgent care services	Treatment of a sudden or severe onset of illness or injury
usual and customary charges (U&C)	Based on the range of fees charged by physicians, health care facilities, or other health care providers in the same geographical area for the same or similar services. CIGNA HealthCare has the exclusive right to determine the usual and customary charges.
utilization management/ review	A process used to review whether health care services are medically necessary and the most beneficial to your care

Appendix B. Members' Rights and Responsibilities

One of CIGNA HealthCare's goals is to work in cooperation with participating physicians to provide you with access to quality care and programs. The CIGNA HealthCare Quality Management Program is based on industry standards and objective measures that help CIGNA HealthCare evaluate the quality of care and services received by CIGNA HealthCare ***members***. The program also helps CIGNA better focus their improvement efforts. The Quality Management Program allows for input from ***members*** and ***providers*** through regular analysis.

You may write or call CIGNA HealthCare at the address or telephone number on your CIGNA HealthCare ID card with your opinions, ideas, and thoughts. Additionally, your participation in plan surveys gives direct feedback on plan performance and policy development.

You Have a Right to:

- Medical treatment that is available when you need it and is handled in a way that respects your privacy and dignity
- Get the information you need about your health care plan, including information about services that are covered, services that are not covered, and any costs that you will be responsible for paying
- Have access to a current list of ***providers*** in the CIGNA HealthCare network and have access to information about a particular ***provider's*** education, training, and practice
- Have your medical information kept confidential by CIGNA HealthCare employees and your health care ***provider***. Confidentiality laws and professional rules of behavior allow CIGNA HealthCare to release medical information only when it is required for your care, required by law, necessary for the administration of your plan or to support CIGNA HealthCare programs or operations that evaluate quality and service. We may also summarize information in reports that do not identify you or any other members specifically.
- Have your health care ***provider*** give you information about your medical condition and your treatment options regardless of benefit coverage or cost. You have the right to receive this information in terms you understand.
- Learn about any care you receive. You should be asked for your consent for all care, unless there is an ***emergency*** and your life and health are in serious danger.
- Refuse medical care. If you refuse medical care, your health care ***provider*** should tell you what might happen. We urge you to discuss your concerns about care with your doctor. Your doctor will give you advice, but you will always have the final decision.

- Be heard. CIGNA's complaint-handling process is designed to hear and act on your complaint or concern about CIGNA HealthCare and/or the quality of care you receive, provide a courteous, prompt response, and guide you through CIGNA's grievance process if you do not agree with CIGNA's decision.
- Make recommendations regarding CIGNA's policies on ***member*** rights and responsibilities. If you have recommendations, please contact CIGNA's Customer Service at the number on your CIGNA HealthCare ID card (1-800-244-6224).

You Have the Responsibility to:

- Review and understand the information you receive about your health care plan. Call CIGNA's Member Services when you have questions or concerns
- Understand how to use CIGNA HealthCare services
- Show your CIGNA HealthCare ID card before you receive care
- Schedule a new patient appointment with any new CIGNA HealthCare network ***provider***, build a comfortable relationship with your doctor, ask questions about things you don't understand, and follow your doctor's advice. You should also understand that your condition may not improve and may even get worse if you don't follow your doctor's advice.
- Understand your health condition, and work with your doctor to develop treatment goals that you both agree upon to the extent that this is possible
- Provide honest, complete information to the ***providers*** caring for you
- Know what medicine you take, why, and how to take it
- Pay all payments for which you are responsible, at the time service is received
- Keep scheduled appointments and notify the doctor's office ahead of time if you are going to be late or miss an appointment
- Pay all charges for missed appointments and for services that are not covered by your plan
- Voice your opinions, concerns, or complaints to CIGNA's Customer Service and/or your ***provider***
- Notify your employer as soon as possible about any changes in family size, address, phone number, and coverage status

Appendix C. Member Discounts

Sandia National Laboratories is providing the following discount programs information strictly as a convenience to CIGNA HealthCare ***members***. Sandia cannot guarantee any discounts, results, or performance for the following programs:

CIGNA HealthCare Healthy Rewards®

Provides discounts for ***members*** from ***participating providers*** including:

- Weight Watchers
- QuitNet® and Tobacco Solutions™ smoking cessation programs
- 10,000 Steps exercise programs
- Chiropractic care
- Magazine discounts
- Optical shop
- Eye exams, frames, and lenses
- Laser vision correction
- Hearing care
- Acupuncture
- Anti-cavity products
- Curves®

Some programs may not be available in all states. A discount program is not insurance, and the ***member*** is required to pay the ***provider*** the entire amount minus the applicable discount provided through the Healthy Rewards®. You can locate ***providers*** participating in your area by logging into mycigna.com or by calling 1-800-870-3470.

Appendix D. Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule

Effective April 14, 2003, a federal law known as the Health Insurance and Portability and Accountability Act of 1996 (***HIPAA***) requires that health plans protect the confidentiality of private health information. A complete description of your rights under ***HIPAA*** can be found in the Plan's privacy notice.

This Plan and Sandia Corporation will not use or further disclose information that is protected by HIIPAA (protected health information) without your written authorization except as necessary for treatment, payment, health plan operations, and plan administration, or as permitted or required by law. By law, the Plan requires all of its business associates to observe ***HIPAA***'s privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit plan of Sandia National Laboratories.

Under ***HIPAA***, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, to receive an accounting of certain disclosures of the information and, under certain circumstances, to amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under ***HIPAA*** have been violated.

This Plan maintains a privacy notice, which provides a complete description of your rights under ***HIPAA***'s privacy rules. A copy of this notice will be available upon request by contacting the Sandia Benefits Office. If you have questions about the privacy of your health information or you wish to file a complaint under ***HIPAA***, please contact the ***HIPAA*** Privacy Officer in the Sandia Benefits Office.